HEALTH SECURITY

The President's Report to the American People

THE WHITE HOUSE
DOMESTIC POLICY COUNCIL

Foreword by Hillary Rodham Clinton

HCFA Information
Resource Center

THE WHITE HOUSE
WASHINGTON

October 1993

My Fellow Americans:

Every American must have the security of comprehensive health benefits that can never be taken away. That is what the Health Security Act is all about.

Americans are blessed with the world's finest doctors and nurses, the best hospitals, the most advanced medical technology, and the most promising research on the face of the earth. We cherish — and we will never surrender — our right to choose who treats us and how we get our care.

But today our health care system is badly broken.

Insurance has become a contest of finding only the healthiest people to cover. Millions of Americans are just a pink slip away from losing their health coverage, one serious illness away from losing their savings. Millions more are locked into jobs for fear of losing their benefits. And small business owners throughout our nation want to provide health care for their employees and families but can't get it or can't afford it.

Next year we will spend more than one trillion dollars on health care — and still leave 37 million Americans without health insurance, and 25 million more with inadequate coverage. Skyrocketing health care costs have forced workers to trade wage increases to maintain health benefits and crippled our nation's manufacturers in global competition. And every month that passes without health care reform adds billions to our national deficit.

In short, all the things that are wrong with our health care system threaten everything that's right. To preserve what's right and fix what's wrong, we must get the system under control — and put people first.

The Health Security Act is grounded in six basic principles: security, simplicity, savings, quality, choice and responsibility.

Security means providing every American with comprehensive health benefits that can never be taken away. We must — and we will — outlaw insurance company practices that discriminate against consumers and small

businesses, and make care available to all Americans, no matter where they live or how old or sick they are.

Simplicity means reducing the paperwork that frustrates all of us and wastes countless hours and billions of dollars. We must cut through the red tape and free doctors and nurses to return to what they do best — care for patients.

Achieving savings starts with giving groups of consumers and small businesses the same buying clout as large employers to bargain for fair prices. Communities, companies and health plans across the nation are learning to discipline health costs. We must follow their lead.

Quality means improving what is already the highest quality care in the world. It means a new emphasis on keeping us healthy rather than waiting until we get sick, and giving consumers and providers the information they need to judge quality for themselves.

Choice means preserving our right to choose our doctors and increasing our choice of health plans. We must protect the doctor-patient relationship that lies at the heart of good health care.

Responsibility starts with those who profit from our current system but carries on to each and every one of us. It means every employer and employee must contribute something to the cost of health care, even if that contribution is small.

These principles are the guiding stars that we will follow on our journey toward health care reform. I am convinced that if we agree on these basic values, we can preserve all that is right with American health care, and fix what is wrong.

Our history — the history of challenges met, and obstacles overcome — teaches us that we can succeed. After decades of false starts, we must find the courage to change. And when our work is done — when we provide every American with true health security — we will know that we have answered the call of history and met the challenge of our time.

Health Security

The President's Report to the American People

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Foreword

Hillary Rodham Clinton

Together, we stand at a unique moment in history. In the coming months, we have an opportunity to accomplish what our nation has never done before: provide health security to every American — health care that can never be taken away.

The debate over health care reform that will unfold over the next several months touches all of our lives and the lives of our children, our parents and generations to come. Because this issue is so critical to all of our futures, it is important that all of us have the opportunity to understand the complex issues and difficult choices that lie behind the design of any comprehensive reform effort.

That is why we have written this book — to lay out the dimensions of the crisis that confronts our nation, explain its elements and complexities, and state the case for comprehensive reform as proposed in the Health Security Act.

Book after book has been written about the intricacies of the health care system and the difficulties of addressing these problems. But most of them have not been written for people like you and me — people who may not be experts in health care policy but need and want to understand an issue so vital to our nation and our future.

I invite each and every American to read this book, to listen to the stories told here, to think about the issues and grapple with this complex — but solvable — problem. Then I invite every American to join in the debate.

Every month, two million Americans lose their insurance for some period of time. Every day, thousands of Americans discover that, despite years of working hard and paying for health insurance, they are no longer covered. Every hour, hundreds who need care walk into an emergency room because it is the only place they can go. And business owners, large and small, struggle to stay afloat

while providing coverage for their families and employees.

Each time someone loses health coverage or is denied insurance, their experience becomes another chapter in a growing national tragedy. Anxiety and fear about the cost of health care affect tens of millions of Americans — those with health insurance and those without. Even those with the very best benefits worry that their insurance might not be there tomorrow or may no longer be affordable.

Over the past months, I have had the extraordinary opportunity of listening to thousands of Americans talk about health care. I've sat in living rooms talking to farm families. I've stood on loading docks talking to people who have worked for 10, 15, and even 20 years without insurance. I've visited hospitals, talking to doctors and nurses. I have learned firsthand about the tragedies of hard-working families who simply cannot get the health care they deserve.

I have read letter after letter of the more than 800,000 we have received at the White House from people all over our nation who took the time to sit down and share their concerns about health care. I have been moved by stories of parents who cannot afford a prescription for a child who is sick and hurting, of families barely hanging on financially and emotionally because of a health care crisis, of people trying to start a new business suffocated by skyrocketing insurance costs, of older Americans forced to choose between food and medicine, and of young people just leaving school unable to afford insurance.

I have carried their stories in my mind as we worked long and hard to devise solid answers to tough questions. The President's Health Security Act is a product of all the people who took the time to share their ideas, their research, and their personal experiences with us. And, as we move forward in this great national discussion, we must focus on these people, their health care, and their peace of mind — not solely on theories or statistics.

The concerns that were expressed again and again — from those who need care and those who give care — convinced me of one point: although America can still proudly boast the world's finest health professionals and astounding medical advances, our health care system is broken. If we go on without change, the consequences will be devastating for millions of Americans and disastrous for the

nation in human and economic terms.

As a mother, I can understand the feeling of helplessness that must come when a parent cannot afford a vaccination or well-child exam. As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. As a sister, I can see the inequities and inconsistencies of a health care system that offers widely varying coverage, depending on where a family member lives or works. As a daughter, I can appreciate the suffering that comes when a parent's treatment is determined as much by bureaucratic rules and regulations as by doctors' expertise. And as a woman who has spent many years in the workforce, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage.

As an American citizen concerned about the health of our nation, I stand with you as we confront this challenge that touches all of us. We can and will achieve lasting, meaningful change.

Chapter I

WHY WE NEED REFORM

"You know, there's that old saying: If it ain't broke, don't fix it...This system is broken and desperately needs to be fixed...If I were talking about this as a patient, I would say that it is in intensive care and we're not seeing the kind of vital signs that would lead us to believe it will recover."

—A doctor at St. Agnes Hospital
Philadelphia, PA

In many ways, the American medical system represents our nation at its best, pioneering in the most noble of human pursuits, the healing of the sick. It is the result of five decades of national investment — investment in research into disease and prevention, training of doctors, nurses and technicians, and construction of hospitals and medical schools.

Today tens of thousands of dedicated health care professionals apply their unmatched skills to the world's most advanced technologies and procedures. They deliver some of the best health care on earth. No other health care system exceeds our level of scientific knowledge, professional skill and technical resources.

But America's health care system also presents our nation with one of its gravest challenges.

Bring together any group of citizens and the dimensions of the health care crisis emerge from their stories. Stories about insurance

coverage lost, policies cancelled, fear of financial ruin, better jobs not taken, endless forms filled out. They are stories of frustration and insecurity — and, too often, pain and fear.

Today, everything that is wrong with the American health care system threatens everything that is right. That is the reality that drives the call for fundamental reform, the reality from which President Clinton's Health Security Act arises.

Rising Insecurity

From the 1940s through the 1970s, the United States made steady progress toward broader health care coverage. Employment-based insurance and public programs expanded to reach more people and offer more benefits. Beginning in the 1980's, however, the number of Americans lacking health insurance has increased steadily — while health care costs have increased at ever-rising rates.

The result: growing insecurity. Today, according to estimates prepared by Families USA, more than two million Americans lose their health coverage every month. Many get it back within a few weeks or a few months, but every day a growing number of Americans are counted among the more than 37 million who go without health insurance — including 9.5 million children. Millions more have health coverage so inadequate that a serious illness will devastate their family savings and security.

Unlike other nations that have made health coverage a right of citizenship, the United States continues to treat it as a "fringe benefit" of employment, something that can be given or taken away. Over the course of any two-year period, one in four Americans learns how easily that privilege can be taken away, leaving them vulnerable to financial ruin. Others watch anxiously as their health benefits erode. Even those with the best benefits wonder what will happen if they lose a job or change jobs.

Americans value what health care can do *for* them; increasingly, many fear what the health care system can do *to* them.

At the root of the problem lies our health insurance system, which gives insurance companies the right to pick and choose whom to

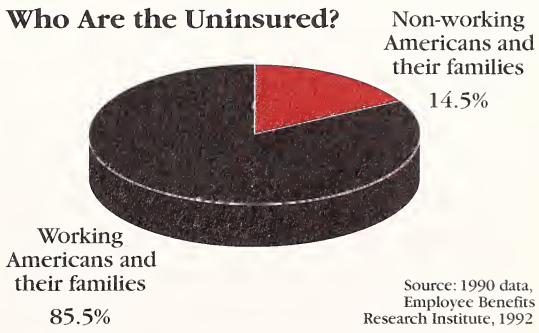
cover. Risk selection and underwriting — the practice of identifying the healthiest people, who pose the least risk — divide consumers into rigid categories used to deny coverage to sick or old people, or set high premium rates.

"The way the system works now, even employed, insured people are just one major illness away from financial disaster."

K.P.
West Lafayette, Indiana

The result is a system that is stacked against individuals, families and small businesses. Millions of Americans have lost their insurance when they got sick and needed insurance most. People with pre-existing conditions — an insurance term for medical conditions or diseases diagnosed before people apply for coverage — either cannot obtain coverage or can often only obtain it at exorbitant prices. Many lose their insurance coverage when a spouse dies or they divorce.

Among the 37 million Americans who lack insurance, 85 percent belong to families that includes an employed adult. Those who work part-time or are self-employed, often cannot obtain group coverage. Fear of losing insurance locks millions of Americans into jobs they want to leave; changing jobs or starting a new business can mean losing health insurance. And many people stay on welfare to get government health benefits they could not obtain if



they were employed in minimum wage jobs.

For small businesses, health security has become almost impossible to achieve. Insurance companies charge small businesses higher rates than they charge major corporations, while refusing to cover some industries considered high risk. Small business owners that want to provide insurance can find themselves priced out of the market, leaving them unable to protect their families or employees.

"My husband and I own and operate a small business. This year we will make our employees pay for any increase in premiums and may drop [some benefits] altogether. Our company cannot shop around for lower cost health insurance because I am uninsurable."

B.M.
Phoenix, Arizona

Prompted by ever-rising costs, employers of all sizes have reduced health coverage benefits, raised deductibles, limited coverage and switched to hiring more part-time and contract workers in part to avoid paying health benefits. Sometimes without realizing it, workers sacrifice wage increases for health benefits, making a tradeoff between what they deserve and what they need. What many Americans fear most about losing a job is losing their health insurance.

Even for Americans employed by the largest corporations, rising health costs present an increasing competitive disadvantage, prompting renegotiation of benefits, reductions in coverage, higher deductibles, limits on choice of doctors, and attempts to shepherd employees into one health plan. As costs continue to rise, these trends become more pronounced — and increasing numbers of American families find health security beyond their reach.

This growing insecurity also has a great impact on older Americans. Any pharmacist will tell you that thousands of elderly people must decide every week between buying medicine and buying food. Doctors who care for the elderly know that cutting down on a dosage to stretch a prescription or skipping a refill has become commonplace, particularly among the elderly who live only a little above the poverty line.

At the same time, a second and perhaps more daunting challenge confronts us: the growing need for security against the devastating costs of long-term care for the elderly and people with disabilities. With the number of Americans over age 85 projected to double by the year 2010, the need for long-term care is expected to rise dramatically as the next century begins, affecting not only those who need care but their families as well.

In the past, the United States has attempted to remedy the gaps in our health care system by expanding public programs or adding new programs aimed to fill specific needs. Community health centers, public health clinics, clinics for migrant workers, and public hospitals — all add up to a patchwork of services covering specific populations, but we have never met the growing need for reliable and secure health coverage.

"When my two sons were 3 and 6, Spencer and Evan were diagnosed with cystic fibrosis. In the blink of an eye, my two beautiful, healthy boys became part of our worst nightmare. We had to face the fact that we could lose them to this dreadful disease. We live in constant fear of losing our medical coverage...
Without the drug coverage that we now have, it would cost us at least $1500 a month for their medicine alone. These little boys are virtually uninsurable...As mothers we need to protect our children, and I don't want to feel frightened about this all my life."

A.B.
Pleasanton, CA

Growing Complexity

American health care is choked by paperwork and strangled by bureaucracy. Administrative costs are higher in the American health care system than in any other country, and rising rapidly.

Confusion, complexity and increasing costs stem from the peculiarities of our health insurance system. Consumers experience it around the office or the kitchen table, when they are faced with piles of incomprehensible forms or when an insurance company refers them to the fine print in a policy to answer a question. A change in jobs or a move to another state can mean deciphering a whole new set of documents and learning a whole new set of rules.

"While we go about our business caring for our patients, we are being buried in paperwork. Everyday, my mailbox is filled with directives, new regulations and papers to sign. The truth is, if I read all my mail, there would be no time left to see my patients."

Dr. Jules Zysman

For small businesses, too many health care dollars go to administration not to actual care. Firms with fewer than five employees face administrative costs that absorb as much as forty cents of every premium dollar, compared to about five cents for larger companies — one reason why many small businesses do not have health insurance.

The sheer number of insurance companies and health plans also adds costs. Hospitals, clinics, doctors and other health providers must deal with hundreds of different insurance plans, each with its own benefit package, exclusions and limitations — and mountains of forms, rules, rates and payment procedures to follow. Each insurance carrier, federal program and type of policy — be it health insurance, auto insurance, or workers' compensation — has its own requirements. Hospitals have been forced to establish whole departments,

create new occupational categories and hire special clerks to handle the paperwork.

In an attempt to control costs and improve quality, private insurance companies and government programs require doctors and other professionals to seek approval before providing treatment, and submit case records for reviews.

For example, a government program or insurance company considering a $30,000 hospital bill has no direct knowledge of the case or the services delivered. Reviewers want evidence that the care was necessary, that it was delivered, and that the bill is accurate and justified.

Every doctor's office and hospital must hire staff to document every service delivered, enter record codes, send out bills, and process other paperwork. They must determine whether an individual qualifies for health coverage, which company carries the primary policy, whether the services are covered, whether another policy covers the same care, how much each company is willing to pay, and how forms need to be filled out. Those staff then spend hours on the telephone with insurers arguing about what's covered and what's not. In many cases, these steps are only the beginning; receiving payment can take weeks.

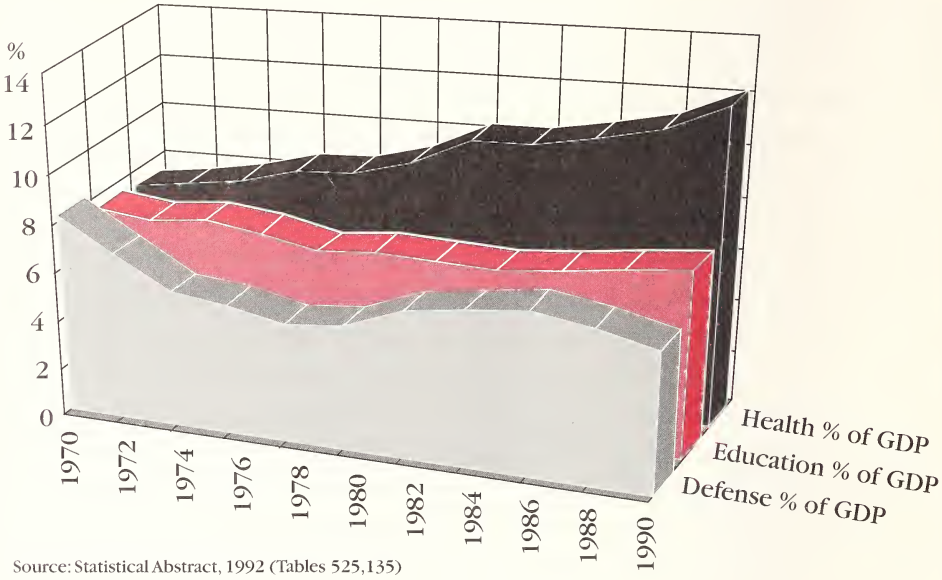
Doctors, nurses and other professionals feel frustrated by bureaucracy, and worry that outside controls compromise their ability to make decisions about treatment. The relationship between doctors, nurses and their patients cannot help but be strained when the "hassle factor" and paperwork drain time and energy away from the delivery of care.

Rising Costs

Between 1980 and 1992, American health care spending rose from 9 percent of Gross Domestic Product (GDP) to 14 percent. Without reform, spending on health care will reach 19 percent of GDP by the year 2000. If we do nothing, almost one in every five dollars spent by Americans will go to health care by the end of the decade, robbing workers of wages, straining state budgets and adding tens of billions of dollars to the national debt.

American workers already feel the impact of rising health costs in

In 1990, the U.S. spent more on health care than on education and defense together, and the gap is widening each year.



Source: Statistical Abstract, 1992 (Tables 525,135)

their paychecks. Had the proportion that health care makes up of workers' wages and benefits held steady since 1975, the average American worker would be making $1,000 a year more today. If current trends continue, real wages will fall by almost $600 per year by the end of this decade.

For every American family and business that purchases health coverage, the real cost of health care is substantially higher than most of us realize. We pay insurance premiums, deductibles (the amount we pay each year before insurance kicks in), plus whatever co-payments or co-insurance (the amount we pay that insurance doesn't cover) our policies require. And ll those payments include a hidden 10 percent surcharge — in the form of higher bills — to cover the more than $25 billion in care that hospitals and doctors provide every year to people who cannot pay. Finally, we pay a payroll tax to cover the cost of Medicare, and other local, state and federal taxes to support the safety net of public programs that help fill in the gaps.

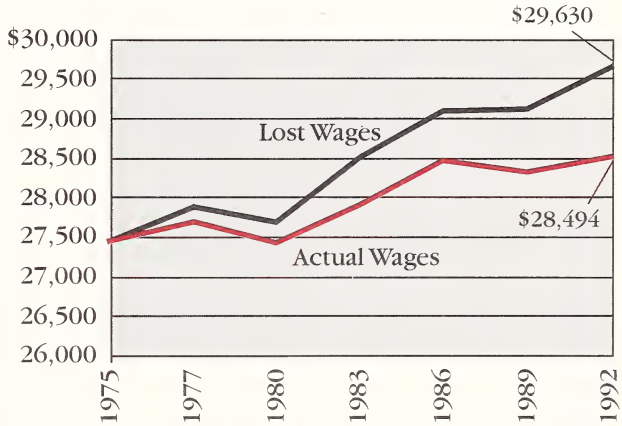
For America's employers, these costs put us at a disadvantage in international competition. Health costs in the United States, for

example, add about $1,100 — about twice as much as in Japan — to the cost of every car made in America.

Rising health care costs deal the same blow to government budgets that they do to workers, families and businesses. If current rates continue, health spending will consume as much as 111 percent of the real increase in federal tax revenues during this decade. The same holds true at the state and local level, where increasing demands for public spending on health care, threaten state budgets and drain resources. For the first time in our history, state spending on health care now outstrips spending on education. Health care will consume a third of projected real increases in state and local budgets during this decade.

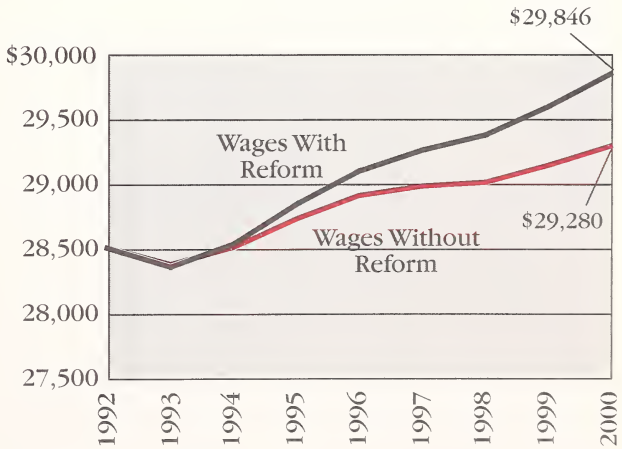
TODAY

If health care had been reformed in 1975, American workers would have over $1,000 in extra wages every year.



FUTURE

Without reform workers will lose almost $600 per year in wages by the year 2000



Source: Commerce Department; Office of Management and Budget

Rapidly escalating costs are particularly threatening to the security of two population groups — Americans older than age 65 and the severely disabled — for whom we decided decades ago to extend health security under the Medicare program. But with growth in Medicare spending running 23 percent higher than the rate of inflation over the last decade, calls to cut Medicare have become commonplace.

The excessively high cost of health care is not the result of forces beyond our control. Other advanced countries provide coverage for all their people at lower and more stable costs and with higher levels of consumer satisfaction (and, in some cases, life expectancy). The American health care system consumes enough money to provide health security to every citizen and legal resident over time. As in other countries, the financial discipline needed to make care affordable can also keep health costs in line with the rest of the economy.

The fundamental problem in America is not that we spend too little for health care. It is that we don't get good value for the billions of dollars we spend.

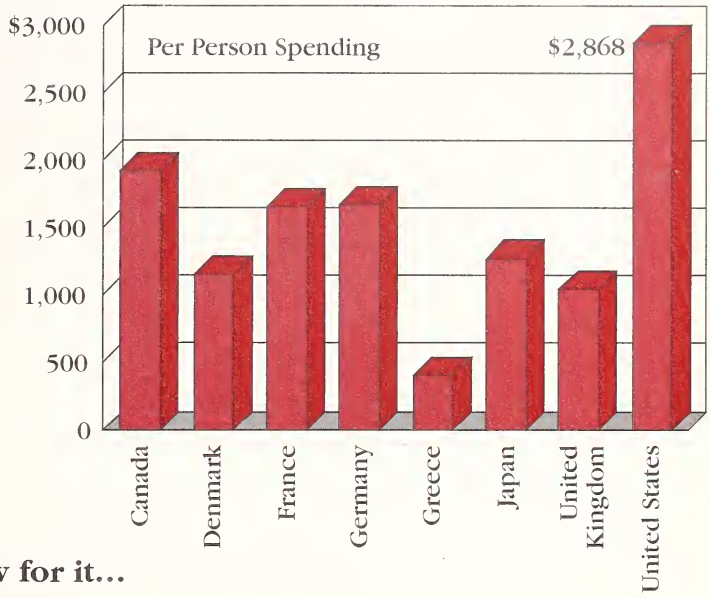
Much research has demonstrated the waste and inefficiency of the health care system — as any doctor, nurse, patient or consumer can verify. First, we train too few doctors who provide the basic health care that most Americans need. Second, we neglect the basics of good medical care — such as preventive services — while investing too much in expensive, high-tech equipment that sits idle. Experts also estimate that health care fraud drains more than $80 billion each year from legitimate needs.

The incentives built into our health care system have also led to striking variations in the cost and frequency of medical treatments.

"Solutions must be found for spiraling health care costs that are eroding the competitiveness of U.S. companies in international markets and causing lower wages, higher prices for goods and services, and higher taxes here at home."

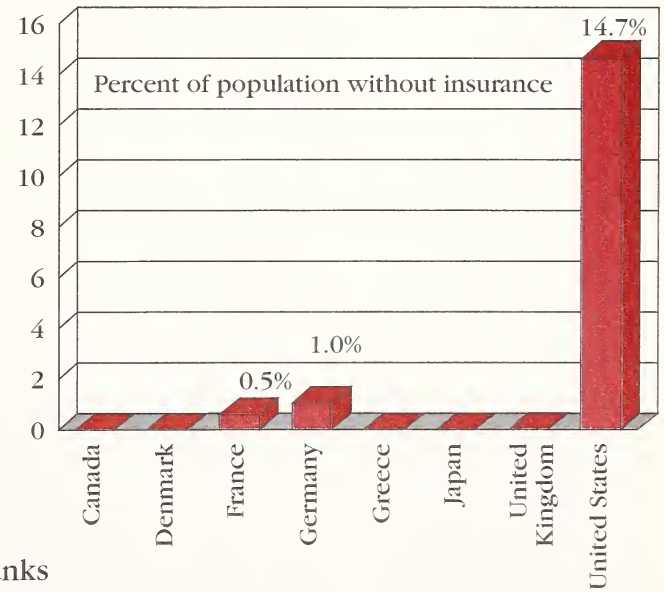
Kenneth L. Lay,
Chairman and CEO of Enron Corporation

America Spends More Than Its Competitors on Health Care...



with less to show for it...

- Fewer Americans have health security



- The United States ranks
  - 19th in infant mortality rates
  - 21st in life expectancy for men
  - 16th in life expectancy for women

Source: Organization of Economic Cooperation and Development; Department of Health and Human Resources

Working at the Dartmouth Medical School, one research team compared how often patients covered by the Medicare program went into the hospital. The team discovered that elderly patients who lived in Boston were 1.5 times as likely to be sent to the hospital as those in New Haven. As a result, the average cost of care for Medicare beneficiaries living in Boston was twice as high as for those living in New Haven. But the researchers found no evidence that Medicare patients were any healthier in one city than in the other.

Other studies have documented similar variations. A study published recently in *The New England Journal of Medicine* found that after adjusting for differences in age and sex, Medicare payments for doctor care for patients varied from $822 in Minneapolis to $1,874 in Miami — with no discernible difference in health to justify the difference in cost. The current system offers few incentives to probe why these variations occur.

After years of attempting to slow the frightening rate of increase in health care costs by tinkering with the existing system, it is clear that only comprehensive reform will work. Only a fundamental change of direction — a change that reduces the waste and bureaucracy and turns today's upside down incentives right side up — can bring about the savings needed to make the promise of security real. States and communities across the country are proving that it can be done; now we must set the entire nation on this positive course.

Decreasing Quality

While the American health care system features some of the world's best quality care, the constant improvements in quality are now threatened. Today, we have no clear sense of what treatments work best and which treatments should be used in different situations. And our neglect of preventive care means that we are not as healthy as we could be.

Traditionally, Americans have assured medical quality by setting standards and then sending regulatory agencies to search for those who fail to meet them. In its oldest form, federal and state laws require health professionals and institutions to satisfy minimum criteria for licensing and certification. But while these procedures are

necessary to protect consumers from substandard care, they have done little to improve quality or reward excellence.

Government and private sector regulators have written thousands of pages of rules governing everything from the qualifications of nurses' aides to the square footage of hospital rooms. Review agencies require doctors, nurses and hospitals to document each step in treatment and scrutinize case records. For many health professionals, quality assurance has come to mean nothing more than outside reviewers poring over records in search of errors. Too often quality programs just mean interference and punishment.

"The duplication of documentation, the authorization forms, the insurance claims forms and all of the complicated and often more contradictory instructions devised by the more than fifty insurance plans we accept are all overwhelming."

Dr. Lillian Beard
Pediatrician
Children's Medical Center
Washington, D.C.

Traditional quality systems have not produced the information that would be most valuable to doctors, nurses or consumers. Doctors and health care managers are frequently unaware of what happens where they work — for example, how often surgeons perform various operations, at what costs and with what results. They are even less likely to know how their performance compares to that of other professionals in the same community, much less across the country.

Since doctors and hospitals don't know how they measure up, patients are in the dark on most medical decisions, unaware of risks and benefits of alternative treatments or settings. Information that would allow them to make meaningful comparisons does not exist. Making this information available would give consumers a way of knowing that the care they receive is high quality and cost-effective.

Declining Choices

Free choice of doctors and other health care providers cuts to the core of the American health care system and the center of the doctor-patient relationship. For patients, the ability to keep seeing their doctor — someone familiar with their medical history and their family — can mean the difference between a good experience and a frightening one, sometimes even the difference between successful and poor outcomes. Perhaps no issue is more important to patients.

But today even patients who have good private coverage increasingly have restricted choices. Almost every practicing doctor has had patients call the office upset because they had to transfer to another physician when their employer or a job change caused them to switch them to insurance carriers. And doctors often find themselves discouraged from joining all the health plans in which they want to participate, separating them from some of their patients.

Faced with rising costs, many American employers increasingly limit the health care choices workers once took for granted. Today only one in three companies with fewer than 500 employees offers its workers a choice of health plans. Increasingly, the one plan available may limit choice of doctors, often disrupting valued relationships.

In one other sense, choices are limited in today's health care market. When the elderly or disabled need long-term care, they generally have only one place to go if they want coverage: the nursing home. Despite the fact that many would rather receive care in their homes and communities -- a choice that is usually less expensive than institutional care -- they are blocked from using federal health care dollars for such care. These peculiar rules and wrongheaded incentives single out for punishment those groups that deserve the security of guaranteed care.

Growing Irresponsibility

Irresponsible behavior in our current system begins with those who profit the most: insurance companies that search for only the healthiest people to cover while excluding the sick and the elderly; and pharmaceutical companies that sometimes charge Americans three times what they charge citizens of other nations for prescrip-

tion drugs.

The medical malpractice system also fosters irresponsible behavior. Although the direct costs of medical malpractice are not great — experts estimate that they account for no more than 2 percent of health care spending — the threat of frivolous lawsuits breeds distrust and fear among doctors and other health providers. Procedures that doctors and hospitals perform to protect themselves from lawsuits adds billions more in "defensive medicine" to our bills.

This lack of responsibility can be seen throughout the system. Many people pay nothing for their health care, and in turn, contribute to skyrocketing costs. In the United States people who have no health insurance or who have inadequate coverage still receive care — but often it's the most expensive type of health care delivered in the most expensive place: the emergency room. Doctors, hospitals and clinics are forced to pass those costs along to everyone else — leading to what's known as "cost shifting" — which contributes to rapidly rising health spending.

Take the example of two businesses in a small town, a gas station and a car wash. Ever since he opened his business, the gas station owner has provided good health insurance coverage for his employees. Down the street, the owner of the car wash wants to provide insurance coverage, but he does not because he can't get a reasonable rate from an insurance company.

Not having health insurance doesn't protect the employees of the car wash from injury, of course. So when one of them gets hurt in an accident, he or she goes to the emergency room. The doctors provide treatment and the hospital sends the bill knowing full well that the patient cannot pay all or, in some cases, any of it. In turn, the hospital raises its rates for other patients to make up the difference. In effect, the gas station owner and his employees are paying for the health care of the car wash owner and his employees.

The bottom line is simple: every American pays when a company or individual fails to assume responsibility for health coverage or when insurance companies price people out of the market. Those who pay for health coverage end up paying for those who can't or don't. Restoring responsibility is vital to providing health security for every American.

An American Challenge

Like a patient denying the symptoms of serious illness, for decades America has put off confronting the crisis in health care. Comprehensive health care reform has long seemed so formidable, complex and costly that we have denied the threat that continuing on the same course poses to our own lives, the lives of our children, and the course of our nation.

The cost of doing nothing far outweighs the cost of reform. One of every four Americans stands to lose health coverage at some point in the next two years. By the year 2000, one of every five dollars earned by Americans will go to health care. The average worker will sacrifice more than $600 in annual wages to pay for health care coverage. Rising costs will force firms to cut back further on benefits and scale back choices.

Despite its many achievements, America's health care system is threatening millions of people each year, undermining security, the ability to compete, and economic strength. The challenge of health reform is to alter that course, to reverse the harm while improving the quality of care, to replace fear with guaranteed security.

Chapter 2

PRINCIPLES OF REFORM

"Some things, like universal access, are not negotiable. And that's exactly the way it should be."

Former Surgeon General
C. Everett Koop, M.D.
September 1993

Six principles underlie the Health Security Act: security, simplicity, savings, quality, choice and responsibility.

SECURITY

Guaranteeing comprehensive benefits to all Americans.

1) The Health Security Act guarantees all Americans comprehensive health benefits, including preventive care and prescription drugs, and ensures they can never be taken away.
2) The Health Security Act outlaws insurance company practices that hurt consumers and small businesses. Insurers will not be able to deny anyone coverage or impose a "lifetime limit" on people who are seriously ill. And the plan outlaws charging older people more than younger people, and sick people more than well people.

3) The Health Security Act sets limits on what consumers pay for health coverage. It limits how much health care premiums can go up each year, and sets maximum amounts that families will spend out-of-pocket each year, regardless of how much or how often they receive medical care. The Health Security Act removes "lifetime limits" on coverage, ensuring that benefits will always continue, no matter how much care you need.
4) The Health Security Act will preserve and strengthen Medicare, adding new coverage for prescription drugs. A new long-term care initiative will expand coverage of home and community-based care.
5) Access to quality care will expand, so that people know that there will always be a doctor that they can get to and a hospital that will treat them. Particular attention will be paid to the needs of underserved rural and urban areas.

SIMPLICITY

Simplifying the system and cutting red tape.

1) The Health Security Act reduces paperwork by giving everyone a Health Security card and requiring all health plans to adopt a standard claim form to replace the hundreds that exist today.
2) The plan cuts insurance company red tape by creating a uniform, comprehensive benefits package, standardizing billing and coding, and eliminating fine print.

SAVINGS

Controlling health care costs.

1) The Health Security Act increases competition, forcing health plans to compete on price and quality, instead of on who does the best job of excluding sick people or old people. Health plans will have an incentive to provide high-quality care and control costs to attract more patients.

2) The plan strengthens buying clout by bringing together consumers and businesses in "health alliances" to get good prices on health coverage. Today big businesses use their clout to get low prices; alliances will allow consumers and small businesses to get a good deal, too.
3) The plan lowers administrative costs by cutting paperwork and simplifying the system.
4) The plan places limits on how much premiums can rise, acting as an emergency brake to ensure that health care costs don't spiral out of control.
5) The Health Security Act criminalizes health-care fraud, including overbilling, and imposes stiff penalties on those who cheat the system.

QUALITY

Making the world's best care better.

1) The Health Security Act arms doctors and hospitals with the best information, latest technology and feedback as it empowers consumers with information on quality — forcing health plans to compete on quality in order to attract patients.
2) The Health Security Act also invests in new research initiatives — into new ways to make prevention work, new treatments, and new cures for diseases.
3) The Health Security Act emphasizes preventive care — putting a new emphasis on keeping people healthy, not just treating them after they get sick. The comprehensive benefits package pays fully for a wide range of preventive services not covered by most insurance plans today. And it builds a stronger health care work force — training more primary care doctors, nurses and other health professionals to provide care into the next century.

CHOICE

Preserving and increasing the options you have today.

1) The Health Security Act ensures that you can follow your doctor and his or her team into any plan they choose to join.
2) All Americans will be able to choose from at least three and likely many more kinds of health plans offered — no matter where they work. The choice of plan will be yours — not your employer's. And every American will be able to switch plans every year if they're not satisfied with their care or service.
3) The Health Security Act makes it possible for more elderly and disabled Americans to continue to live in their homes and communities while receiving long-term care.

RESPONSIBILITY

Making everyone responsible for health care.

1) Without setting prices, the Health Security Act asks drug companies to take responsibility for keeping prices down.
2) To discourage frivolous medical malpractice lawsuits the plan requires patients and doctors to try and settle disputes before they end up in court, and it limits lawyers' fees.
3) Everybody — employers and employees alike — will be asked to pay something for health care coverage, even if the contribution is small. Low-wage small businesses and workers will get substantial discounts, but everyone must take responsibility.

Chapter 3

HOW THE NEW SYSTEM WORKS

How Reform Will Affect You

After health reform goes into effect, every American citizen and legal resident will receive a Health Security card. Once you get your card, you will never lose your health coverage — no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you start a small business, you're covered.

The card guarantees you a comprehensive package of benefits that can never be taken away. Those benefits are as comprehensive as the ones that most Fortune 500 companies offer their employees. The package includes doctor and hospital care, as most insurance plans do, and also covers prescription drugs and a host of other services. [See chapter 4] You will also receive something rarely found in today's insurance plans — preventive care.

No matter which plan you choose, you will also receive something. The plan will pay 100 percent of the costs for a wide range of preventive care services, including prenatal care, well baby care; immunizations; disease screening for adults, such as mammograms, Pap smears, and cholesterol tests; and health promotion programs, like stop-smoking classes and nutrition counseling.

You will be able to choose your doctor. Every American will have a choice of health plans — and plans will enroll everyone who applies, regardless of age, occupation or medical history. While prices will vary among plans, each health plan will charge everyone the same price for the guaranteed, comprehensive benefits package. Employers or insurance companies won't decide how or where or from whom individuals

get their care — you, the consumer, will decide. You will be able to follow your doctor into a traditional fee-for-service plan, join a network of doctors and hospitals, or become a member of a health maintenance organization (HMO). For older Americans, the Medicare program will be preserved and strengthened with new coverage of prescription drugs. There will also be expanded options for home and community-based long-term care.

Like today, almost all of us will be able to sign up for a health plan where we work. Brochures will give you easy-to-understand information on several health plans — the doctors and hospitals involved, an evaluation of the quality of care, and prices. There will be regular "report cards" that measure quality and consumer satisfaction for each plan. Once a year, consumers will have a chance to choose a new plan. If you are not satisfied with your care or service, you can "vote with your feet" and pick a new plan, something most people can't do today.

If you're self-employed or unemployed, you can sign up through the health alliance in your area by phone or through the mail. Alliances, run by boards of consumers and local employers, will contract with and pay health plans, guarantee quality standards, provide information to help consumers choose plans, and collect premiums. They will, in effect, take on roles similar to major corporate benefits offices. The largest national corporations — those employing 5000 workers or more — have the option of continuing to self-insure their employees or joining regional alliances. For the consumer, particularly people who work, the local alliance will be largely invisible. It will help you get good prices on insurance, but you'll still sign up for health care at work.

In order to get care, most people will do what they've always done — go to the same doctors, hospitals, pharmacies, or other providers. More providers will organize into "networks" — groups of doctors, nurses, hospitals, and labs that cooperate together to coordinate the care of their patients and control costs.

Once you've picked a plan, if you need to go to the doctor for a check-up or if you get sick, you'll simply take your Health Security card, show it at the doctor's office, and they'll take care of you. Then

you'll fill out one standard form, and you're done. So when you get sick, you won't be buried in forms — and neither will your doctor or hospital.

Unless your employer chooses to pay your entire premium, you will contribute about 20% of the cost. Your share of premiums will be deducted from your paycheck, the same way most people pay now. If your employer wants to pay the full cost of your premiums, that will always be an option. In addition, individuals will pay limited co-payments or deductibles to their health plans as part of their coverage. People who are either self-employed or unemployed, but still can afford to contribute, will send in a monthly check for insurance. (See charts at the end of the chapter.)

Today, most businesses offer health coverage to their workers. For these businesses, health care reform which provides universal coverage will mean a tremendous benefit. No longer will these businesses bear the costs of other businesses and their employees -- through higher premiums and higher taxes to pay for people without coverage, or by covering spouses working for other businesses. And no longer will premiums continue to rise out of control. This will mean that businesses will be more competitive and be able to create more jobs.

Currently, health care costs represent an increasingly large financial burden for businesses of all sizes. Firms now pay as much as 20 percent of their total payroll just to provide health care coverage for their workers. Under the Health Security Act, no business will ever pay more than 7.9 percent of their payroll for health insurance.

"Successful implementation of health care reform is one of the best pieces of news American business could receive."

Henry Aaron
Health Economist, Brookings Institute

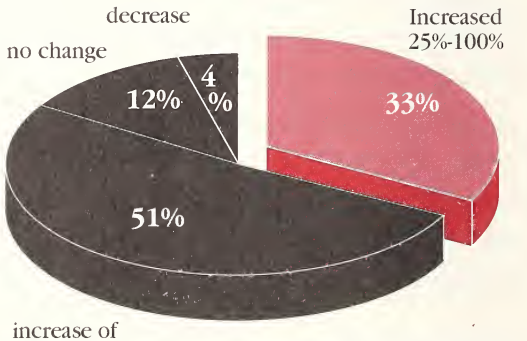
Small Business in the New System

Today's health care system is stacked against small business owners, their families and employees. Small businesses, who are too small to have benefits departments, are burdened by high administrative costs – as much as 40 cents of every dollar of their premiums – compared to only 5 cents for large companies. They are charged higher premiums because they don't have the bargaining power that large companies do to get the best prices from insurance companies. And they are the most vulnerable to sudden rate hikes if even one employee gets sick.

Despite these obstacles, most small businesses – particularly those with more than one or two employees -- do provide insurance for their workers. And most of those that do not cover their employees want to provide insurance but find it impossible in a health care system that discriminates against them.

Small Businesses Face Rising Costs Today

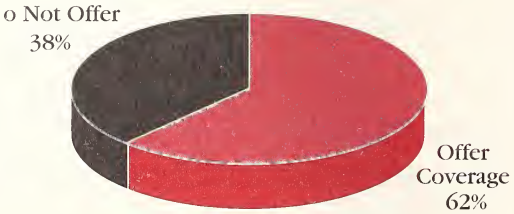
Last year alone, one third of small businesses experienced health care cost increases of more than 25%.



Source: National Small Business United

Most Small Businesses Already Provide Insurance

Employees in Firms with Less than 100 Employees



Source: Dept. of Labor; SBA Calculation of CPS Data

The Health Security Act creates a level playing field that will finally allow small businesses to provide affordable coverage for their employees without being discriminated against because of their company size. The Wall Street Journal has said that the Health Security Act will be *"an unexpected windfall"* for many small businesses that currently provide insurance to their employees. These companies will likely pay substantially less under reform – because of lower premiums and reduced administrative costs. And those small businesses who are charged far too much today to provide a "bare-bones" package for their families and employees will finally be able to afford to provide a comprehensive benefits package – in many cases without spending much more than they currently pay for less coverage today. The Health Security Act will level the playing field for small businesses in the following ways:

- Small businesses will no longer face outrageous administrative costs because they will join together to get the same benefits – in terms of bargaining power and administrative simplicity – that big businesses have today.

- Small businesses will be charged the same rate as large businesses to provide coverage to their workers.

- Small businesses that now provide insurance will see their premiums decrease when they no longer have to pay for uninsured workers.

- The Health Security Act will outlaw insurance company practices – ranging from price gouging to refusing to insure entire industries – that make it impossible for small business owners to get insurance today for their families or employees.

- Reform will also streamline the workers' compensation system -- which is a never-ending source of frustration, fraud, and high costs for small businesses today.

- Self-employed Americans will now be able to deduct 100% of their premiums – instead of the 25% allowed by law today.

Discounts for the Smallest Companies

Those small businesses that provide no health coverage today will have to help pay for their employees' health care. The Health Security Act is specifically designed to protect small businesses and help them make the transition to a system that guarantees their families and employees the health security they deserve. Those low-wage businesses with 75 or fewer employees will receive substantial discounts on the price of insurance, depending on the size of the company and the average wage.

- For the smallest firms that pay the lowest wages -- such as restaurants -- the percent of payroll devoted to health care may be as low as 3.5 percent. That amounts to $350 a year for a company with average wages of $10,000 -- or less than $1 a day per employee.

- These discounts apply to most small businesses with less than 75 employees, even those that currently provide health insurance to their workers.

- The vast majority of small businesses -- especially the "Mom and Pop" firms that are so vital to the American economy -- will find that the savings they reap in the cost of health insurance for their own families will substantially offset any new spending required to cover employees.

An Overview of the New System

The Health Security Act rejects the idea of a government-run health care system. Health care will remain rooted in the private sector. Most people will get insurance through their employers, as nine out of ten people do today. The plan achieves universal coverage and recognizes that some direction from the government — including asking everyone to pay their fair share — will be necessary to achieve that goal. But it leaves the tasks of delivering care and controlling costs to the private market.

The Health Security Act seeks to build on what works best in the American economy and fix what is broken. What works best is a competitive market that provides products and services to Americans at the highest quality and lowest price.

But the competitive power of the market is not working in today's health care industry. Today, insurance companies compete not on the basis of price and quality, but by excluding people who might become sick.

The system is also broken in another fundamental way: small and mid-sized businesses, the self-employed, and average American families are powerless to bargain with insurance companies. Today, only big business has the clout to negotiate lower prices. The little guy — the local hardware store, the entrepreneur, the young family — ends up getting stuck with high prices and excessive cost increases.

The Health Security Act seeks to fix these problems so that all Americans benefit from a truly competitive health care marketplace. First, the Health Security Act outlaws insurance company discrimination based on age, sex, or medical condition. Instead, it makes insurance companies compete based on how well they cover all of us, and not how well they exclude some of us.

The Health Security Act joins consumers and small businesses together in health alliances so that they can have the same bargaining power that the largest companies get. After reform, every American will have bargaining strength to get low prices and high quality care.

For the first time, consumers will be in the driver's seat when it comes to finding quality health care. Health plans will be forced to compete on providing the best care at the most affordable prices. This will provide incentives for everyone in the health care business to operate more efficiently — incentives that don't exist today.

Flexibility

Realizing the goals of the Health Security Act requires that we build in flexibility. National reform establishes a framework within which states and local communities make their own choices. Americans cannot, and need not, come to one vision of the single best approach to health care.

Consequently the pace of reform will vary across the country. Some states are already well along in addressing the need for health reform. Some have served as models, forging paths that other states will follow as they implement reform. Under the Health Security Act states will begin implementing reform in 1996, and all states are to begin implementing reform by the end of 1997.

Reflecting the geographic diversity of our nation, the Health Security Act allows for each state to tailor health reform to its unique needs and characteristics as long as it meets national guarantees and standards for quality and access to care. Certain states, in fact, may choose to set up a single-payer system, where one agency collects and distributes all health care dollars for that state. Flexibility is essential because we know that what works in North Dakota may not work in North Carolina.

Although the Health Security Act establishes a national framework to achieve the goals of reform by spelling out standards and the comprehensive benefits that every American must receive, it does not prescribe how to deliver care or organize services. It leaves those decisions to consumers, doctors, nurses, hospitals and managers of health plans, rather than to the government. The Health Security Act establishes protection at the national level to ensure security – the solid foundation upon which American communities are free to build. Then it gets government out of the way to allow the reformed, private market to work.

What You Pay

What a Comparison Won't Tell You

Before comparing what you pay today with what you will pay under Health Security, remember this: The Health Security Act guarantees you something no amount of money can buy today — true health security, no matter what happens to you.
Ask yourself these questions about your plan today:

- Do you have a comprehensive benefits package — with prescription drug coverage and preventive care at no additional cost?
- Do you have any guarantee that you won't have to pay a larger share of your premium next year?
- Do you get coverage that kicks in right away, after only a small deductible?
- Are you free from "lifetime limits" so you're guaranteed coverage no matter what happens?
- Does your insurance company charge you the same even if you are older or have a pre-existing condition?

If the answer to any of these is "no", you will get a better value for your premium under the Health Security Act.

Your Premium:	MONTHLY**			
	TODAY		REFORM	
	Range	Average	Range	Average
 Two Parent Family With Children	$0-$180	$76	$0-$91	$73
 Single Parent Family With Children	$0-$180	$76	$0-$80	$64
 Married Couple With No Children	$0-$180	$76	$0-$80	$64
 Single Person	$0-$60	$25	$0-$40	$32

** Preliminary average estimates, based on 1994 numbers; will vary from state to state.

Low-income Americans may be eligible for discounts.
This applies to:
- Two Parent Families with income below $22,200
- Single Parent Families with income below $18,400
- Married couples with income below $14,600
- Single people with income below $10,800

* Estimate of 150% of poverty in 1994. Actual cutoffs will vary by year and growth in consumer price index.

What If I Am...

65 or older: Older Americans will continue to receive their health care through the Medicare program, as they do today. Older workers and their spouses will receive the same comprehensive coverage as other working Americans through the health alliances.

Unemployed: Unemployed people will still have health coverage without interruption, paying only their 20% portion of the premium with discounts based on their income. Those with non-wage income — such as interest payments — may also be responsible for some or all of the employer's (80%) share.

Part-time Worker: Part-time workers will pay for a portion of their health insurance premiums. As long as they are working, their employers will also pay part of their premiums. Depending on their income, part-time workers may receive discounts for the remainder.

Self-employed/Independent Contractor: Today, the self-employed are only allowed to deduct 25% of their health care premiums from their taxes. Under reform, they will be able to deduct 100% of their health care costs. As with any business, they pay the employer's share, and are eligible for any discounts that apply. They also pay the individual/family share, and may be eligible for discounts on that as well, depending on their income.

Retiree, 55-65: Faced with rising health costs, many companies have been dropping the health coverage that their retired workers depend on. Under reform, retired American workers will only be responsible for their 20% share of the premium. However, former employers may choose to cover the 20% share, or may be required to do so under collective bargaining contracts.

Financial Protection...

	TODAY	REFORM
DEDUCTIBLE The amount you pay before your insurance kicks in	Almost half of today's plans have deductibles larger than $200 per person. Some are as high as $3,000.	Many plans will have no deductible. For the plans that do, deductibles will be $200 for an individual and $400 for a family.*
LIFETIME LIMIT A limit on what insurance companies pay	In 60% of today's insurance policies, your insurance can run out if you get very sick.	There will be no limit on your total lifetime benefits.

* Preliminary estimates, based on 1994 numbers.

CO-PAYMENTS

Your co-payments — the amount you pay out-of-pocket when you go to a doctor — will be limited and uniform, protecting you financially and making it easier to choose among health plans. Co-payments will vary according to the type of plan you choose. For a wide range of preventive services, there will be no co-payments in any plan. Low-income Americans may receive discounts on their out-of-pocket costs.

FEE FOR SERVICE: Patients pay 20% of the cost of each visit after the $200 individual deductible or $400 family deductible is reached. They pay nothing after they reach the annual out-of-pocket maximum of $1,500 for an individual or $3,000 for a family.

DOCTOR NETWORK (PREFERRED PROVIDER ORGANIZATION): This plan offers low co-payments ($10) — with no deductible — if patients use the doctors within the network ("preferred providers"). If patients choose doctors outside the network, they have higher co-payments (20% of each visit) — once they've paid the $200 individual deductible or the $400 family deductible. They pay nothing once they've reached the out-of-pocket maximum ($1,500 for an individual; $3,000 for a family).

HEALTH MAINTENANCE ORGANIZATION (HMO): Patients pay no more than $10 for each doctor visit. There are no co-payments for hospital care and no deductible has to be met.

Chapter 4

SECURITY

"Six months ago, my sister-in-law, Pam, had a disabling stroke. Pam is only 39 years old, and she's a severe diabetic. Six months have passed, her short-term memory has deteriorated, her vision is leaving, and it looks as if my brother will either have to hire someone to come into their home full time to care for her, or put her in a nursing home, which his medical plan does not cover.

My brother's attorney has advised him to divorce Pam so that her medical bills don't pull him into financial ruin. My brother has two young sons that he's caring for and in order to continue to provide for them, he is giving this consideration...

A man who loves his wife must divorce her so that her misfortune (in sickness and in health) does not leave him with the inability to raise their family."

A.P.
Toledo, Ohio

Americans buy health insurance to provide security for themselves and their families. Security, in its full sense, is what health care reform must give us all. We must be secure that no American will face exclusion from coverage because of illness, occupation or age. We must be secure that health benefits will be comprehensive enough to keep us healthy and cover our health care needs throughout life.

Comprehensive Benefits

Under the Health Security Act, all American citizens and legal residents will be guaranteed a comprehensive package of health benefits that can never be taken away. They will receive a Health Security card entitling them to enroll in a health plan. Everyone will have a choice of at least three — and, in most communities, many more — health plans. And no matter which plan people choose, they will receive the comprehensive benefits package.

Covered Benefits

Benefits covered under the nationally guaranteed comprehensive package carry no lifetime limits. The package covers the following health services when they are medically necessary or appropriate:

- Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services.
- Emergency services.
- Services of health professionals delivered in professional offices, clinics and other sites.
- Clinical preventive services.
- Mental health and substance-abuse services (for details, see box on mental health and substance abuse).
- Family planning services.
- Pregnancy-related services.
- Hospice care during the last six months of life.

- Home health care, including skilled nursing care, physical, occupational and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care.
- Extended-care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year.
- Ambulance services.
- Outpatient laboratory and diagnostic services.
- Outpatient prescription drugs and biologicals, including insulin.
- Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury.
- Durable medical equipment, prosthetic and orthotic devices.
- Routine ear and eye examinations every two years.
- Eyeglasses for children under age 18.
- Dental care for children under age 18.

Planned Expansion of Benefits

Beginning in the year 2001, the nationally guaranteed benefits package will expand to include the following:

- Preventive Dental care for adults.
- Orthodontia if necessary to prevent reconstructive surgery for children.
- Expanded coverage for mental health and substance abuse treatment.

The coverage provided by the comprehensive benefits package equals that provided by America's major employers, such as Fortune 500 companies. It covers a full array of clinical services, from doctors' offices, to clinics, to hospitals, to rehabilitation centers, to laboratories, hospices, home-health agencies and other professional offices.

The comprehensive benefits package provides far more coverage for clinical preventive services than traditional insurance. It waives the usual co-payments and deductibles for a wide range of preventive services that are vital to keeping people healthy. Preventive services covered without co-payments include prenatal, well-baby and well-child checkups, physicals for adults, immunizations and regular screening tests such as mammograms and Pap smears.

The Health Security Act particularly expands preventive services for certain low-income women and children. By fully funding the

Preventive services

The Health Security Act offers comprehensive coverage for a specific set of preventive screenings, laboratory tests and periodic checkups. Included in the benefit package, at no cost to the consumer, is coverage for preventive care such as immunizations and specific screening tests.

Some preventive services will be targeted to groups that have a high risk for certain diseases, such as men considered especially vulnerable to cardiac problems and women with a close family history of breast cancer. Children will receive a full range of prevention services, including immunizations, well-baby checkups and developmental screenings at no extra charge.

Special Supplemental Food Program for Women, Infants and Children (WIC), more families will be able to receive nutrition counseling and get nutritious food — part of the overall strategy for keeping people healthy rather than waiting until they get sick.

"We believe reform will enhance both medical security for the nation's 65 million children and peace of mind for their parents. We are especially impressed by the commitment of yourself and the First Lady to ensuring all children have access to appropriate health care, because it is such an important investment in the nation's future"

Lawrence A. McAndrews, President and CEO
National Association of Children's Hospitals
and related institutions.
September 21, 1993

The benefit package also expands traditional coverage of mental health and substance abuse treatment. Insurance companies often tightly limit their coverage of mental health; they adopt that policy partly because they depend on the public mental health system — and the taxpayers who pick up the bills — to serve millions of people who lack coverage for even basic treatment, or who suffer from chronic or serious illness. The Health Security Act eliminates the lifetime limits on mental illness that can devestate family savings; and it provides coverage for regular clinical visits, and offers more flexible care.

For millions of Americans, the comprehensive benefits package will provide a significant expansion of coverage. Those whose current benefits are more generous — a much smaller number — will have every right to continue receiving richer benefits. Nothing in the Health Security Act prevents employers from providing more extensive benefits, with no strings attached.

MENTAL HEALTH AND SUBSTANCE ABUSE

The Health Security Act offers Americans guaranteed coverage for mental illness and substance abuse, ending the agony that families confront when a serious mental illness occurs.

The benefit package gradually expands coverage for mental illness and substance abuse, both for inpatient and outpatient therapy. Out-patient services will include diagnostic office visits for medical management, substance abuse counseling, and relapse prevention. The benefit package also provides coverage for a wide range of new approaches, such as intensive care delivered outside the hospital.

The Health Security Act eliminates lifetime limits on mental health and substance abuse treatments. Initially it contains limits on the number of days of inpatient and outpatient treatment, but it commits to removing those limits by the year 2001.

Types of services covered:

- Inpatient care
- Alternative treatment programs which provide intensive care outside hospitals
- Outpatient therapy with requirements for patients to share part of the cost.
- Brief office visits and medical management for patients who take medication.

Not everything is covered in the benefits package. It would just be too expensive. Examples of services that are not covered include:

- Services that are not medically necessary or appropriate
- A private room in a hospital
- Adult eyeglasses and contact lenses
- Hearing aids
- Cosmetic surgery

Individuals will be free to purchase supplementary insurance, although the comprehensive benefits package leaves little need for additional coverage. Employers are also free to offer additional benefits or absorb co-payments and deductibles.

However people choose to receive health care, the Health Security Act guarantees all Americans something no amount of money can buy in today's insurance market: the knowledge that they will always have comprehensive health benefits that can never be taken away — no matter what happens in their lives or their jobs. If they lose a job or change employers, coverage will continue without interruption. If they move, get married, separate from a spouse, experience a catastrophic illness or confront any other crisis, their health coverage will continue uninterrupted.

Insurance Reform

The Health Security Act outlaws discriminatory insurance practices that prevent millions from obtaining health coverage today. It will return the concept of health insurance to its roots: offering protection to everyone whether they're healthy or sick, young or old. It will put an end to the practice of underwriting — searching for only the healthiest people to insure.

Under the Health Security Act, health plans will be required to:

- Enroll everyone who applies, whether they're healthy or sick, young or old;

- Charge everyone the same price for the same comprehensive benefits — no more charging higher rates to sick people, older people, or people with pre-existing conditions;
- Provide coverage without resorting to "lifetime limits" that cut off coverage when people need it most; and
- Limit deductibles in fee-for-service plans to $200 for an individual and $400 for a family.

By establishing a uniform, comprehensive benefits package, the Health Security Act no longer makes it advantageous for insurance companies to shape benefits and policies that attract the healthy and avoid the sick. Health alliances, in turn, will help organize the private market so that consumers — for the first time — can compare plans and providers and make informed choices. Their mission will be to promote competition among health plans based on quality and price — not on who can screen out sick patients.

Limits on What Consumers and Businesses Pay

The Health Security Act also takes several important steps to protect families and businesses from rising health costs and financial ruin. To provide secure financial protection against the most devastating illnesses and injuries, it prohibits so-called "lifetime limits" and restrictions on the amount of medically necessary or appropriate care. The limits, which are included in six out of every ten insurance policies today, can mean bankruptcy for families in which catastrophic illness strikes. The Act also sets maximum annual out-of-pocket limits; even those who select the most expensive plans can spend no more than $1,500 a year for an individual, or $3,000 for a family. Insurance picks up the full cost of any medical care that exceeds those limits.

The Health Security Act also limits deductibles — the amount people pay each year before insurance kicks in, which can run into the thousands today — to $200 for individual's and $400 for families who choose traditional fee-for-service plans.

Employers will pay a maximum of 7.9 percent of their payroll for health care. Small businesses — those with fewer than 75 employees

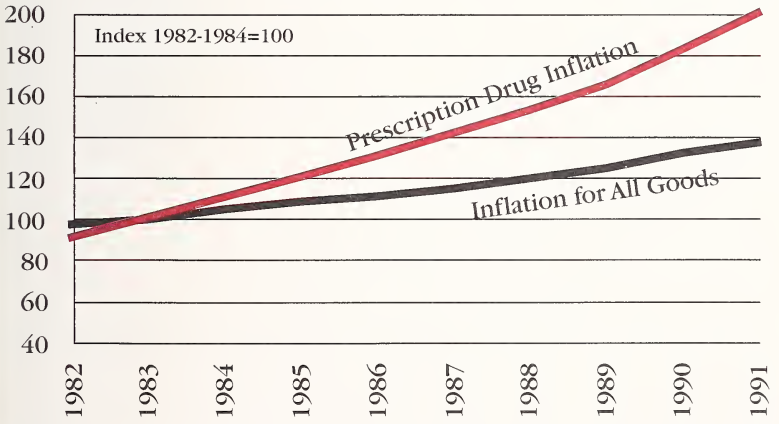
— will receive discounts of between 30 and 80 percent, compared to what the average large business pays. And the self-employed will be able to deduct from their taxes 100 percent of their health care, up from today's 25 percent.

PROTECTING OLDER AMERICANS

The Health Security Act preserves and protects the Medicare program, providing older Americans with the health security they deserve. People covered by Medicare will see little difference in how, where or from whom they receive their health care, but they will receive new prescription drug benefits.

Americans eligible for Medicare will automatically receive the new prescription drug benefit — which will cover drugs and biological products, including insulin, approved by the Food and Drug

Older Americans and Prescription Drugs



- More than 60% of those older than 65 have no insurance for drug costs.[1]
- Prescription drugs are the largest cost of daily living for 45% of all people over 65.[2]
- More than 5 million Americans over age 55 say they have to choose between buying food and paying for medication.[3]

[1] USA Today, 9/25/93
[2] USA Today, 9/25/93
[3] Robert Wood Johnson Foundation

Source: U.S. Department of Labor, Bureau of Labor Statistics

Early Retirees

When Americans over age 55 find that health problems or other events require them to stop working, they often confront the worst possibilities in the current health insurance market: because of age, or medical conditions, individual coverage is difficult to obtain or very expensive. Under health care reform, American workers who retire between the ages of 55 and 64 will never have to worry about losing their health coverage.

Under the Health Security Act, individuals over age 55 who retire before they are eligible for Medicare will pay for their coverage like other people who do not work and will be eligible for discounts based on income.

When reform is fully implemented, at the end of this decade, early retirees will become eligible for greater discounts requiring them to pay only the portion of their insurance premium that they paid as employees, unless they have an annual income higher than $100,000 for an individual, or $125,000 for a couple.

To be eligible for this greater discount, early retirees will have to have worked for ten years, the same standard used for eligibility under the Social Security Act.

The coverage for early retirees in the Health Security Act will provide a major financial benefit to employers who traditionally cover the cost of retirees' health premiums.

Employers who wish to provide coverage for any or all of the retired employee's share of the premium or for cost sharing required by health plans will continue to do so, as they do today.

When they reach age 65, retired workers have the choice of staying in their health plan or enrolling in Medicare, just as they do today.

Administration — when they enroll in the Part B benefit, which covers physician and other outpatient services. Under the drug benefit, there will be a $250 annual deductible for each person. Individuals on Medicare will also pay 20 percent of the cost of each prescription up to a maximum of $1,000 over the course of a year.

Part B premiums will increase about $11 a month to cover 25 percent of the cost of this new benefit. But for seniors who have Medigap policies, which cover services not provided by Medicare, premiums for those policies should decline since they will no longer cover prescription drugs.

As Americans enrolled in health plans through alliances turn sixty-five, they can choose between remaining in their health plan or entering the Medicare system.

Older Americans will also see their long-term care options expand and improve under health care reform. The Health Security Act creates a new home and community-based care program and expands the range of choices for disabled individuals who require long-term care.

Among other things, the Health Security Act will:

- Expand home and community-based services;
- Improve Medicaid coverage for people in nursing homes;
- Improve the quality and reliability of private long-term care insurance and provide tax incentives to encourage people to buy it; and
- Provide tax incentives to help people with disabilities work.

ACCESS TO CARE IN RURAL AND URBAN AREAS

The challenges of guaranteeing health security in rural and inner-city communities are essentially similar: both include unusually high numbers of people without health insurance, making it difficult to attract doctors. Scarce economic resources create barriers to organizing effective networks of care.

Greater incidence of poverty aggravates health problems. Many people in these areas require special services — rides to the doctor,

Long-Term Care

Beginning in 1996, a new home and community-based care program will enable older Americans with severe disabilities to remain in their own homes or with their loved ones, yet still receive the care and assistance they need.

Medicaid nursing home coverage will be enhanced, allowing nursing home residents to keep $70 per month for living expenses. States will have the option to provide even greater financial protection by allowing individuals to retain up to $12,000 in assets, instead of today's $2,000.

The Health Security Act also provides tax incentives to encourage people to buy private long-term care insurance that meets new standards, and tax incentives to help individuals with disabilities to work.

babysitting and translators, just to get access to health care services.

Although urban and rural areas have some of the same problems, the circumstances that cause them are often very different. In rural areas, geography is the main obstacle. With a relatively small population spread over a large area and health care professionals in short supply, patients often have to travel long distances to see a doctor. Doctors are reluctant to practice in rural areas because they have no help or support from peers. Without enough doctors, nurses and health facilities, building networks of care becomes more difficult, as does the task of attracting enough health plans to foster competition.

In inner-city communities, the challenge is almost the opposite: crowded cities with culturally diverse populations. Only a few blocks away from world famous academic health centers, residents of low-income neighborhoods contend with a laundry list of health care problems too few doctors and nurses; little or no access to culturally-

sensitive care; high rates of infant mortality and low-birthweight babies; frequent violence; and serious health epidemics such as AIDS.

To serve both communities, the goals of health care reform are similar: increase the economic base for health care through universal coverage, provide discounts to make care affordable, and create incentives to attract health care providers to the area.

The Health Security Act includes new loan programs and invest-

THE MAYO CLINIC

A Model for Reform

If you went searching for the highest-quality medical care in the world, you might not immediately think to head to rural Minnesota. But there in Rochester, you'd find the Mayo Clinic, a magnet for patients all across America.

The largest managed care practice in the United States, the Mayo Clinic is known worldwide for its effectiveness at diagnosing and treating illness, and for the excellent physicians who work there. And they've proved that you can control costs and provide top-flight care, holding cost increases well below national averages.

The Mayo Clinic has led the way in encouraging the development of networks of doctors in rural areas, and linking rural physicians and regional health centers in order to increase the availability of high-quality care. These kinds of rural networks serve as the cornerstone for the Health Security plan's strategy to make care more available for residents of rural and remote areas.

ments to increase the level of service available in underserved urban and rural areas. Expansion of the National Health Service Corps will send new physicians and other health professionals into underserved rural and inner-city communities, substantially increasing the supply of doctors and nurses. Successful programs, such as community and migrant health centers, will expand to increase the number of places where people can find care.

A new program of federal grants and loans will support doctors and hospitals in rural and inner-city communities form their own networks and compete with other health plans. This program will link federally funded clinics with other community providers bolstering their skills to coordinate care, negotiate with health plans, and form their own health plans.

The Health Security plan — by supporting the creation of new clinics and offices and renovating and converting existing clinics and offices — will ensure more and better places to seek care in these areas. In addition, it will improve the level of care — and reduce isolation — for urban and rural residents. This will be done by linking members of the practice networks with each other and with regional and academic health centers through the development of more sophisticated information systems.

Two new programs will overcome barriers to care for hard-to-reach, isolated, or culturally-diverse populations. One will support school health services for adolescents. Another will support transportation, child-care, translation, outreach and follow-up services for those in need of care but who are not being served by current programs.

Hospitals, clinics, doctors and health professionals who traditionally serve in these areas are also eligible for designation as "essential community providers", gaining special protections during the implementation of health reform. To help these key providers adapt to the changes in the system after reform, the Health Security Act requires health plans to contract with essential community providers for five years to enable them to continue to serve the residents in these rural and urban communities who depend on them.

Chapter 5

SIMPLICITY

"Each of our medical insurance policies requires separate and different applications for reimbursement, each of which have to be mailed to different addresses. This mountain of paperwork places an undue burden on older Americans . . ."

J.H.
Venice, Florida

In order to simplify American health care, we must move forward on two fronts. First, we must reduce paperwork by adopting standard insurance forms and clarifying administrative rules. Second, we must strip away the unnecessary layers of regulation and oversight as we hold health plans and providers accountable for results. Streamlining administrative burdens will make our system less daunting and frustrating for consumers and more supportive and flexible for the doctors, nurses, and hospitals on the front lines.

REDUCING PAPERWORK

Guaranteeing all Americans health coverage and establishing a uniform, comprehensive set of benefits represent the first, vital steps toward simplifying health care. If all Americans have guaranteed coverage for comprehensive health benefits, then doctors, hospitals and clin-

ics have less paperwork to do when a patient walks in the door. Doctors, nurses and other health professionals will no longer have to worry which patients are covered for what services. Patients no longer will have to deal with confusing sets of insurance requirements, and will no longer be stuck with huge medical bills because they didn't read the fine print.

The Health Security Card that every citizen and legal resident receives will guarantee that health coverage travels with you as circumstances change, whether you switch jobs or move to another state. Like the cards that activate bank-teller machines, a magnetic strip will provide basic registration information, including identifying the health plan in which you are enrolled. A personal identification number will authorize access to insurance information, reducing the process of registering and billing, but maintaining your privacy.

Protection of Privacy

The Health Security Act establishes the first national privacy protection laws specifically aimed at protecting the medical records of patients.

Under reform, new security standards will protect computer information, ensuring that medical records will be available only to health professionals who have a legitimate need to see them. For example, the bill clerk in the hospital's financial department won't have access to medical information. This is an assurance that few insurers, or hospitals, can offer consumers now.

The Health Security Card will not be a "smart card" — which carries information in a computer chip — a national identification card, or a credit card. It does not hold sensitive information such as medical records. It's simply a way to streamline the billing process, reduce

FOR OFFICIAL USE ONLY **MEDICAL CLAIM FORM**

Health Plan Information

1) Health Plan	2) Health Plan Number

Patient Information

1) Last Name	2) First Name	3) Middle Initial	4) Patient Identification Number
5) Gender	**6) Patient Signature**	**7) Date**	**8) Release Medical Information?** YES ☐ NO ☐

Subscriber Information

1) Last Name	2) First Name	3) Middle Initial
4) Subscriber Identification Number		

Treatment

1) Is need for care:	a) Employment – related?	d) Auto – accident related?
	c) Other, accident – related?	e) Appointment?
	e) Emergency?	

2) Initial Diagnosis	3) Final Diagnosis

4) Description of Patient's Encounter

From	Through	Place of Service	Primary Diagnosis Code	Procedure Code	Units/Days of Service	Covered Charges	Non-Covered Charges	Co-pay Collected	Optional Field
5) Total									

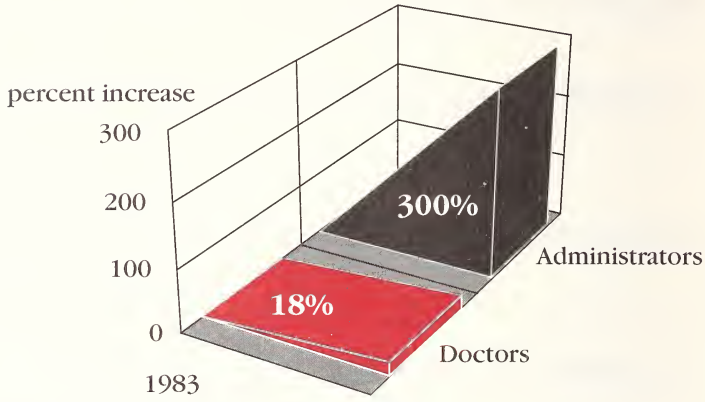
Health Care Provider Information

1) Last Name	2) Identification Number
3) Signature	4) Date

paperwork for doctors and patients, and assure people that they have a comprehensive set of benefits that can never be taken away.

All health plans will adopt a standard form that providers file for services. Replacing the hundreds of different claim and billing forms and codes insurance companies use today will allow health professionals to collect and send the same information to all health plans and alliances. Uniform claim forms will reduce the work that doctors, nurses, and hospitals must do and save an estimated 75 cents for each

In the last decade, the number of health administrators grew 16 times as fast as the number of doctors



Source: Statistical Abstract, 1993

claim. In the long run we will save billions of dollars and free health professionals to spend more time caring for patients.

Today, different types of insurance often overlap, causing confusion, duplication, and waste. Under the Health Security Act, the health care portion of both workers compensation and auto insurance will be covered through regular health insurance. The need to coordinate benefits will decline and small businesses will be rewarded with less confusion and lower administrative costs.

"I know of cases where friends with insurance that covers medication will get prescriptions so that their poorer contemporaries will have the medication they need. Elderly patients try to help those without money for prescriptions by getting a doctor to prescribe for them in their name. We are playing Russian Roulette with medication because our system does not work."

M.J.
Detroit, MI

CUTTING RED TAPE

Simplifying health care also requires aggressive steps to reduce unnecessary regulation. The Health Security Act frees hospitals and other health care institutions from excessive regulations. The federal government will develop national standards for quality which will use them as the basis for licensing hospitals and other health care institutions.

Today, dozens of public and private agencies, inspectors and outside groups inspect hospitals every year to make sure they meet quality standards. Although they all check the same things, they make their visits separately, and hospitals must spend time and money preparing for each visit. Under the Health Security Act, these groups will coordinate their visits, reducing preparation and follow-up time. Rather than routinely examining every hospital each year, inspections will concentrate on institutions with poor histories, following up on complaints and responding to problems.

To reduce frustration and delay, all health plans will have to make clear to participating consumers and doctors precisely how they perform "utilization review" — how the plan determines whether appropriate and effective care was given. Health professionals and industry groups will establish new performance standards, eventually reducing reliance on obtrusive methods of control.

Chapter 6

SAVINGS

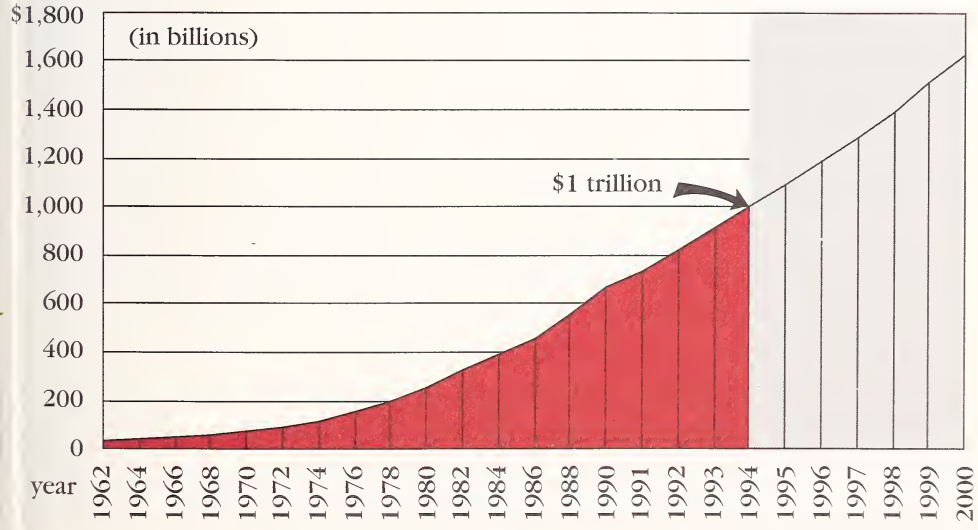
"...health care reform will be good for business. If we can stop runaway health care inflation, businesses like ours can use the dollars we save to increase capital spending and add jobs."

R. L. Crandall
Chairman and President
American Airlines

If we do nothing...

National Health Spending

The U.S. will have a $1 trillion health care bill next year



Source: HCFA, CBO Forecasts

The Health Security Act creates a new framework that will ensure all Americans secure, affordable coverage — and ensure that we spend our health care dollars wisely.

Serious health care initiatives must take aim at the waste, inefficiency, and fraud that bloat our health care system. But the key to achieving the savings that lie at the heart of health reform is to release the American spirit of competition.

Competition, after all, drives the price and quality of most products we buy. Think about a car — different companies build their automobiles, set their prices, and try to win our business. We shop around, kick the tires, make comparisons. Magazines like *Consumer Reports* help us judge what we can't see - safety records and the satisfaction of those who've driven a particular model. Armed with information, we take our pick. We buy the car that best meets our needs for quality, performance, and price.

Health care has never worked that way. Consumers often haven't had any bargaining power, they haven't had good choices, and they haven't had good information to make comparisons. Bringing competition to health care will give consumers the same buying clout in health care they've always had in other arenas. The Health Security Act will improve quality and control costs.

Bringing about savings also requires action on several fronts. Savings requires changing incentives. Savings requires streamlining and simplifying regulations and requirements. And it requires taking aggressive steps to stamp out health care fraud, which drains $80 billion each year from real health needs.

INCREASING COMPETITION

The Health Security Act controls rising costs primarily through the power of a competitive market — empowering consumers to make choices and giving health plans the incentive to compete for their business. Reform will change incentives so that health plans compete on the basis of quality, service and cost — not on screening out sick patients. Physicians, hospitals and other health professionals will be given opportunities to shape a health care system that works for patients.

CONTROLLING PRESCRIPTION DRUG PRICES

In the 1980's, the prices of prescription drug prices rose at quadruple the general rate of inflation. In recent years, several attempts have been made to control drug costs – often involving the use of buying clout to bring down prices.

For example, HMOs and managed care groups are successfully using their bargaining power to negotiate substantial discounts from drug companies. Because they often control the brand of drugs prescribed by doctors, health plans have the power to drive down prices.

Under reform, with the addition of prescription drug coverage, Medicare will become the world's largest purchaser of drugs. And the Medicare program will use its negotiating power to get discounts from the pharmaceutical companies. In addition, with competing health plans trying to become more efficient, more and more buyers will use the same successful negotiating techniques.

Consumers will take their pick among health plans, based on what they have to offer. Which doctors are members of the plan? Are the offices and hospitals convenient? How much do they charge? Since all plans will offer the same comprehensive benefits, people will be

better able to compare than they are today. Consumers will reap the savings from enrolling in health plans that deliver high-quality care most efficiently — and, therefore, charge lower premiums.

Better incentives for health plans will give consumers better value. In the current system, doctors and hospitals get paid extra for each service they perform, necessary or unnecessary. Under reform, health plans and providers make money by keeping their patients healthy — not doing more tests, but giving better care.

It will be in the interest of each health plan to operate efficiently — providing the best quality care at an affordable price. If health plans operate inefficiently, they will lose money. If they start cutting corners, they'll lose patients — and the business that those patients bring. Competition is about finding the balance — providing high-quality care while controlling costs.

STRENGTHENING BUYING CLOUT

Increased buying clout can bring down costs. In today's health insurance market, for example, big companies can go to an insurance company and say, "Look, if you want the business of our 100,000 employees, you've got to give us a good deal." And they get a good deal — comprehensive benefits, high-quality care and affordable prices. But if you don't work for a large employer you're not in a position to bargain, so you're more likely to get high premiums, bare-bones coverage or nothing at all.

The Health Security Act will change that — putting consumers and small businesses in the driver's seat. It's based on the simple idea that bigger buyers get better deals. By bringing consumers and small businesses together in health alliances, the Health Security Act gives everybody else the same buying clout as the big companies.

Today, a major insurance carrier doesn't have to give any kind of deal to the Mom and Pop store in Peoria. But they will not be able to ignore 5000 Mom and Pop stores brought together in an alliance from Central Illinois. That alliance will have more complete information on the costs of health plans, quality of care, service and consumer satisfaction than any buyer in today's market. It will keep enrollment

CALPERS

A Model for Reform

The state employees in California are getting a good deal on insurance — using their buying clout to bring down prices and cut administrative costs.

Adopting a role similar to the one that health alliances will play under health reform, the California Public Employees Retirement System — usually referred to as CALPERS — negotiates with health plans on behalf of almost 900,000 state and local government employees and their families in California. And CALPERS offers its members a choice of 24 different plans. Prices for health plans vary, although all plans provide coverage for the same package of health benefits — just as all plans will offer the same comprehensive benefits package under the Health Security Act.

Because they buy approximately $1.3 billion of health care each year, CALPERS — like the alliances under the Health Security Act — is in a strong position to get a good deal from health plans. Along with holding premium increases well below national averages for the last two years, CALPERS has also succeeded in reducing administrative costs.

records and collect premiums for many people, not just a few, and do it more efficiently as a result. Everyone — not just employees of large companies — will be able to get access to high-quality care at an affordable price.

LOWERING ADMINISTRATIVE COSTS

The Health Security Act simplifies the business side of health care by cutting through the paper jungle generated by some 1,500 insurance companies, and stripping away conflicting regulations imposed by a variety of federal, state, local and private agencies.

Administrative costs take up 40 percent of every health care dollar spent by small firms and the self-employed, with only 60 percent going to buy care. Meanwhile, large purchasers pay only 5 to 7 percent for administrative overhead; 95 percent of their health dollars go to care, as they should. For all private health insurance, the cost of administration totalled $44 billion in 1991, an average of 16 percent of the benefits paid out.

"What the insurance industry burns up in commissions, marketing and claims processing costs is almost unspeakable. [President] Clinton would reduce those costs."

Professor Uwe Reinhardt
Health Economist, Princeton University

Similarly, eliminating some of the duplication among different kinds of insurance — folding the health benefits of auto insurance and workers compensation into one unified health insurance policy, for example — will produce savings. Today, doctors and hospitals often submit separate claims for payment to two or more insurers. Under the new system, everyone will have coverage, and most people will have one and only one source of insurance. Doctors and hospitals will no longer have to sort out conflicting coverage.

LIMITING PREMIUM INCREASES

The increased competition from health care reform will squeeze the waste and excess out of the health care industry that nearly every doctor, nurse, patient, consumer and insurance carrier knows exists.

In order to reinforce the the competitive power of the market, the Health Security Act also creates an enforceable, fail-safe limit on the growth of insurance premiums. This limit reinforces the new incentives that slow the rate of growth in costs and acts as an emergency brake to back up competition. It serves to build in some discipline and certainty so that businesses and families will know their health care costs will not suddenly spiral out of control. It also ensures that the federal government is serious about living within its means. Once American consumers and employers have reaped the gains from savings, the limits on premium growth will be reassessed, based on experience under reform.

REDUCING HEALTH CARE FRAUD

The Health Security Act makes health care fraud a specific crime. The Act takes aggressive steps to combat health care fraud, increase penalties for those who cheat the system and expand enforcement activities. It imposes new prohibitions against kickbacks and conflicts of interest, such as doctors who refer patients to laboratories in which they have a financial stake. And health care providers convicted of fraud and related crimes will be excluded from participation in health plans.

The Departments of Justice and Health and Human Services will lead the anti-fraud effort, organizing an All-Payer Health Care Fraud and Abuse Enforcement Program to coordinate federal, state and local law-enforcement activities. The effort will target practices such as overcharging for services, charging for medical care that was never delivered, giving kickbacks to doctors who refer their patients to certain clinics or pharmacies, and delivering unnecessary services. If providers file false claims against health plans, their assets can be seized and criminal penalties for health care fraud can be imposed. The revenues from seized assets will be funneled back to support anti-fraud efforts.

Chapter 7

QUALITY

"I am a first grade teacher in a very poor neighborhood in North Philadelphia...Many of [my students] have never seen a family physician; many have never even been inside a public health clinic. I was shocked to find that eight out of ten of their absence notes are written by doctors in the emergency room of nearby hospitals...I feel bad for my students who have never had an ounce of preventive medicine, but I feel angry, as do many of my middle-income peers, who are ultimately footing the bill for the emergency treatment these children are driven to."

J.G.
Philadelphia, PA

In many parts of our nation, for many patients, the quality of health care is unparalleled anywhere in the world. The United States boasts the best technology, the most advanced research, and the greatest number of medical breakthroughs of any advanced nation. When it comes to quality, we have a great deal to be proud of. The Health Security Act protects and improves the high standards we have set for American medicine.

But the quality of our health care is uneven, and threatened by serious flaws in the way we measure and report on which health care treatments should be used and which work best. No clear standards

define what is the best medical practice; lack of information compromises the care people get; and inadequate attention to preventive care reduces the effectiveness of treatment and services.

The Health Security Act includes specific provisions to make sure that the high-quality health care delivered in some parts of our country spreads to other areas, and becomes the standard nationwide.

This Act takes steps to arm doctors, hospitals, and health plans with the latest information on state-of-the art treatments and their effectiveness, and arm consumers with information to help them compare the quality of plans.

It measures quality and accountability, focusing on results rather than micromanagement and filling out forms.

It increases funding for health care research to keep American health care and technology state-of-the-art; and it improves health and wellness through unprecedented coverage of preventive care and steps to build a better health care workforce.

BETTER INFORMATION FOR JUDGING QUALITY

Without the information they need to reward high-quality plans with their business, consumers are powerless to force health plans to compete.

Researchers and panels of health professionals have developed new ways to measure the results of different treatments and what type of care and treatment works best. A number of medical professional groups have participated in extensive efforts to develop guidelines for effective medical care for specific conditions and illnesses. The Health Security Act will promote greater sharing and use of information, helping more practitioners benefit from the results.

Many programs around the country have begun using the new approaches to quality, building on better and more available information. Business groups are now joining with doctors, hospitals and health plans to publish information about comparative quality and price. In communities from Nashville, Tennessee to Rochester, New York, and in the state of Pennsylvania, major employers, local hospitals and state governments have begun collecting information that allows businesses and consumers to make valid comparisons among

hospitals and physicians.

Under the Health Security Act, American consumers will benefit from greater access to information, which in turn will further improve quality. They will exercise not only the right to choose doctors, other health providers and health plans, but also the right to make informed choices based on meaningful information about how health plans, health professionals and hospitals perform.

Annual performance reports provided by health alliances will survey consumers and measure how their health plans, doctors and hospitals perform on a set of four critical indicators:

- *Access:* whether care is readily and quickly available;
- *Appropriateness:* whether care fits the condition;
- *Outcome:* whether treatments produce good results; and
- *Consumer satisfaction.*

These information "report cards" will compare health plans and providers, reporting how various plans performed on carefully selected indicators. Researchers know that certain medical indicators provide clues about overall performance: How many children with asthma in this plan ended up in the hospital last year? How many older people who suffered a fall didn't recover their ability to walk? How many patients who suffered heart attacks survived? On the simplest level: How many patients didn't like this plan and chose another?

Performance reports based on these types of indicators will prove valuable to consumers and health professionals. When choosing a plan or providers within a plan, consumers will be able to judge whether they can expect prompt access to treatment, how the care stacks up against competitors, and what other consumers think about the plan. Merely making this information available will force plans and providers to focus on quality.

A reformed health care system that emphasizes accountability can improve the quality of health care, improve safeguards for patients and reduce bureaucratic regulation.

The Health Security Act will replace the outmoded system for measuring quality in practice today, where government bureaucrats and insurance companies second-guess decisions made by doctors and

their patients. In its place will be a quality measurement system focusing on results: Was the treatment the right one? Did it achieve the intended effect? What can we learn from the case? Focusing on results will reduce the paperwork and micromanagement that strangle doctors, nurses, hospitals and clinics. It frees health professionals from intrusive insurance companies and bureaucrats, improves morale, and creates an environment that supports what health professionals are there to do — care for patients.

Under reform, doctors, clinics and hospitals will have to examine ways to make their delivery of care more efficient while improving quality. "Business as usual" will no longer be profitable. Leading hospitals across the country are already moving in this direction. For example, when doctors at the Hospital of Latter Day Saints in Salt Lake City, Utah realized that post-operative wound infections were causing excessive hospital stays, they experimented with changing the timing of administering antibiotics before surgery. Patients got fewer infections, left the hospital earlier, and saved $450,000 in the first year.

INVESTING IN RESEARCH

Under the Health Security Act, there will be significant initiatives to increase research. Advances in medical science, new medications and technology, and innovations in health care delivery will improve the quality of life for all Americans.

Research related to health promotion and prevention of disease will focus on many common illnesses and other priority areas: heart disease, bone and joint disease, Alzheimer's disease, cancer, AIDS, birth defects, mental disorders, substance abuse, nutrition, and health and wellness programs.

Research regarding clinical practice will increase with an emphasis on quality and effectiveness, as well as access and financing. There will be an emphasis on "outcomes research," to help answer questions about what treatment works best for which conditions, so that doctors can provide the highest quality care for their patients. Expanded research will also measure consumer awareness, decision-

making and satisfaction so that the best information is made available to the public. This will ensure that people can make well-informed decisions about their health care.

EMPHASIZING PREVENTIVE AND PRIMARY CARE

Prevention is the cornerstone of the Health Security Act. Incentives for patients and doctors alike to use and prescribe preventive methods are woven throughout. From free coverage of a wide range of preventive services to wellness education and increased research funding, the plan offers unprecedented focus on prevention.

Academic Health Centers

Academic health centers are the sites of the basic research that ushers in modern medical advances — new treatments and cures for human illnesses. They pioneer advanced techniques and procedures, from heart-lung transplants to laser surgery for brain aneurysms.

Under the Health Security Act, academic health centers will continue to train physicians and provide state-of-the-art care. The Act sets aside a portion of all health insurance premiums specifically for academic health centers. Resources will be channeled to centers by a formula that recognizes each center's contributions to education, research, and patient care.

While most Americans will not obtain regular care at an academic health center, the Health Security Act requires that everyone has access to specialized care if needed.

The comprehensive benefits package includes a broad array of preventive services not covered by the vast majority of insurance plans — immunizations, mammograms, well-baby care, and other screenings and early detection techniques to solve health problems before they become serious illnesses. The Health Security Act covers a wide range of preventive services with no coinsurance or co-pay, no matter which plan you join.

The Health Security Act will fundamentally restructure incentives in the health care system. For the first time, every doctor, nurse and health provider will know that they can provide the services they believe are necessary — and know they will be reimbursed.

"The plan recognizes that successful disease prevention and health promotion must address the health plan of both individuals and communities. It provides for universal coverage of clinical preventive services that have been shown to be effective in preventing disease and prolonging life. All these aspects constitute an approach to prevention that is uniquely comprehensive in scope and long overdue."

Roy L. DeHart, MD, MPH
President, American College of Preventive Medicine

As the American health care system has become more complex, specialized, and technical, it has neglected some simpler and, ironically, less costly needs. The cost of treatment for acute illness has soared, but we continue to spend relatively little on preventive and public health services.

Good primary and preventive care is one of medicine's essential responsibilities. Meeting that need represents one of the essential requirements under health care reform. If the American health care system is to provide high-quality care at affordable prices, it must

Public Health

Not all health problems can be addressed by providing individual health care coverage alone. Greater public health strategies are necessary to improve public health awareness, quality of care, and the prevention of future epidemics.

Public health protects communities against infectious diseases, such as tuberculosis and measles, and helps communities discover how to control chronic disease, such as diabetes and heart disease. It also works to protect the environment and educate about health and related issues.

For too long, public health funds have been sapped to pay for individual care. Under the Health Security Act, public health dollars will reach their intended destination -- targeting issues that plague entire populations rather than individuals first. These efforts promise long-term savings in lives and dollars.

strike a better balance between physicians, nurses and other professionals who take care of basic needs and those who provide the most sophisticated and specialized treatment for serious illness.

Primary care doctors and nurses work on medicine's front line. They diagnose and treat routine medical problems, refer patients when necessary, and coordinate specialist care. Family physicians, general internists and pediatricians are the principal primary care practitioners among physicians, and many women also consistently see obstetricians and gynecologists. Advance-practice nurses and physician's assistants provide essential primary care as well.

But the number of doctors providing basic, routine care has

PUGET SOUND

A Model for Reform

Chances are that if you live in the Pacific Northwest, and you belong to a health maintenance organization (HMO), you belong to Group Health Cooperative of Puget Sound. Founded in 1947 and located in Seattle, Washington, Group Health is the single largest provider of health care in the Pacific Northwest, serving 500,000 members. It offers convincing proof of the fact that emphasizing primary and preventive care can mean high-quality care, low costs, and satisfied, healthy patients.

Like the Health Security Act, Group Health covers a wide range of preventive services not covered by most insurance plans. Its efforts have brought results. In fact, Group Health formed the basis for a Rand Corporation study that concluded that providing high-quality care can go hand in hand with controlling health care costs. Another important feature of Group Health is its attention to customer satisfaction, which it measures through regular consumer surveys – much like the surveys proposed in the Health Security Act for all health plans.

declined and many states have prevented advance-practice nurses and other health professionals from taking on as significant a role as they might.

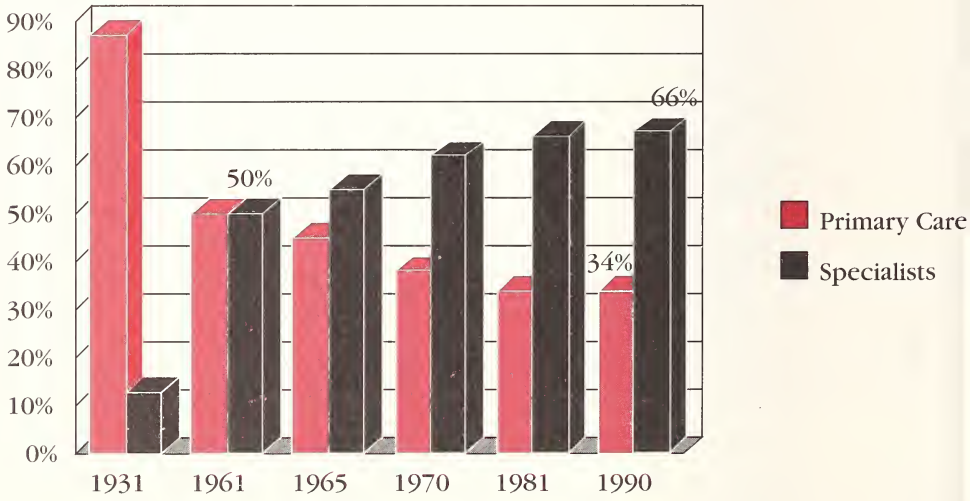
For decades federal policy has reinforced the trend away from training primary care doctors and toward training more specialists. Federal funding of graduate medical education averaged $70,000 for each resident in 1992, with nearly all of the money going toward

training in hospitals. Little went to other health care institutions in local communities that provide more basic care. Between 1980 and 1993, American hospitals increased the number of residents in training from 82,000 to 97,000, with 94 percent of the new positions devoted to training in specialty fields of medicine.

Health care reform will increase the demand for primary care physicians, nurses and other health professionals, correcting the long-standing incentives that discouraged medical students from becoming family doctors. But change won't happen quickly. To encourage American teaching hospitals to switch some residency positions from specialist to primary care, the federal government must make it more worthwhile to train them.

Consequently, rather than pay for graduate medical education without regard to specialty, public and private investment will redistribute

Doctors in the United States: An Unhealthy Mix



Source: Council on Graduate Medical Education, October 1992

the balance between residency slots devoted to primary care and those devoted to specialty training. Other federal programs, including an expanded National Health Service Corps, will support students studying primary care and locating in underserved areas, such as rural

and urban communities. Loan forgiveness programs for medical students who are trained in primary care, and re-training programs for mid-career specialists who want to work as primary care physicians will further boost the number of primary care doctors.

The Health Security Act also proposes several important steps to remove barriers to practice that currently limit the role of advanced-practice nurses. It enables qualified health professionals who participate in health plans to fully use their expertise and ability to provide care. In addition, federal funds will provide additional resources for training nurses, doubling the number of annual graduates. Support will also be provided for training in mental health and substance abuse treatment.

Chapter 8

CHOICE

"The President's proposal guarantees stable and secure health coverage for all Americans, regardless of employment or health status. Patients can stay with the same doctor over time because patients, not employers, control their coverage choices. Patients, not their employers, choose their health plans and their physicians."

American College of Physicians

Americans value the right to decide how and where they get health care. It is a key measure and protector of quality. Yet thousands of Americans are losing that right each year, as rising health care costs force employers to cut back on the number of health plans and doctors they'll cover.

Americans will gain a new level of control over their health care choices through the Health Security Act. For many, no element of reform will be more important than the right to choose their own doctor, hospital or health plan.

CHOOSING A DOCTOR

A fundamental flaw in today's health care system is that employers — rather than employees — have the power to choose health plans and, consequently, the doctors, hospitals and others who provide care.

The Health Security Act corrects that flaw. Through comprehensive

Choice of Doctors

Choice is the basis of the doctor-patient relationship. For patients, the ability to keep seeing their own doctor — someone who knows them and their family — who knows their medical history, who knows how to care for them when they are ill, someone whom patients trust, can mean the difference between a good experience and a frightening one, between a successful outcome and a poor one.

The Health Security Act ensures that consumers can follow their doctor and his or her team to any plan they might join. The Act requires every health alliance to have a point-of-service option, which gives patients the opportunity to see a doctor outside of their plan, although some plans will require extra payment for that option.

If they choose, physicians and other health providers will be able to join more than one health plan. These health care providers may also decide to remain in private practice rather than join a health plan. Patients will still have the opportunity to see their doctor even if he or she is in private practice.

reform, it transfers the power to choose back to individual Americans and their families. It requires both regional and corporate alliances to offer a broad choice of health plans, including at least one plan organized around the traditional fee-for-service style, where consumers visit any doctor they choose, and their health insurer pays the bill.

For patients who choose certain types of health plans, exercising the right to see a doctor who does not participate in the plan will cost more, as it does today. But that right – known as a "point-of-service" option – will always be there, even in HMOs. It reserves for

every American the right to seek the care of doctors and hospitals on the leading edge of treatment if they ever confront an illness in which even specialized care available through their regular doctors and hospital is inadequate. So, if you join a plan that includes your obstetrician, your son's pediatrician, but not your daughter's dermatologist, it will cost more, but you can continue to see them all.

Health reform will also make it easier for patients to follow their doctors, even if their doctors decide to switch health plans. Because an increasing number of employers restrict the choice of plans available to employees, a patient whose doctor leaves one plan probably has little choice but to find another doctor. Under the Health Security Act, the patient will always have the option of switching plans each year, something that most people can't do today.

For doctors and other health providers, health reform also expands choice — the choice of health plans in which they practice. Under the Health Security Act, physicians and other health professionals may participate in as many, or as few, competing health plans as they wish. And because patients are guaranteed a point-of-service option in every plan, physicians will know that patients will be able to seek them out.

CHOOSING A HEALTH PLAN

Millions of Americans choose physicians and other health care providers and pay for their services one at a time through traditional indemnity insurance, a style of coverage usually described as fee-for-service. Over the last two decades, millions of other Americans have moved into so-called "managed care" health plans, including preferred provider organizations (PPOs) or Health Maintenance Organizations (HMOs).

All of those options — and other innovations that will evolve — will continue. What the Health Security Act will provide is the guarantee that a wide range of alternatives will exist and that American consumers, not their employers, will have the opportunity to choose among them.

XEROX

A Model for Reform

Most businesses pick their employees' health plan — but not the Xerox Corporation. Xerox offers its employees a choice of plans. Although it might sound like more trouble than it's worth, Xerox has managed to save money by offering choices.

Before changing the way it dealt with health benefits, annual premium increases of 20% were not unknown at Xerox. So the company started offering its employees a choice of plans at its 250 sites across the country. Xerox would pay based on the cost of the "benchmark" or average-cost plan. If the employee picks a low-cost plan, he saves money. The employee's job was to choose plans based on price and quality — and Xerox hoped that the competition among health plans would drive down costs.

It worked. Xerox's premiums have stopped spiraling higher and higher every year. And Xerox's strategy — using choice and competition to drive down costs — is central to the Health Security Act.

INCREASING OPTIONS FOR LONG-TERM CARE

Expanded choice must also mean a greater set of options for Americans in need of long-term care. Today, choices are not only limited, they are costly. People either pay the full cost of home care out-of pocket, pay the full cost of care in a nursing home, or spend themselves into poverty in order to qualify for government help, most often only for nursing home care.

Long-term care options are expanded and improved under health care reform. The Health Security Act provides a new federal program to cover home and community-based care, an option that most people prefer, and that often costs less than a nursing home.

For those who plan ahead by purchasing private long-term care

Americans with Disabilities

For Americans with disabilities, access to comprehensive coverage without lifetime limits is the most important achievement of The Health Security Act. That guarantee will allow many Americans with disabilities to work without fear of losing health coverage.

New tax incentives will remove obstacles preventing people from seeking employment, opening the door to the personal freedom that employment provides. Employed individuals with disabilities who require personal assistance will be eligible for tax credits covering 50 percent of their costs up to a maximum of $15,000 each year.

Home and community-based long-term care will be provided to Americans of all ages with severe disabilities. People who have cognitive and mental impairments qualify for home or community-based care, as do children under the age of six who depend on technology and would otherwise need institutional care.

States can design their own approaches to home and community-based care. Expansion of care may include homemaker and chore services, respite services, assistive technology, adult day care, rehabilitation and supported employment.

insurance, reform will provide greater protection against faulty or inadequate insurance, and tax breaks on premiums. For disabled Americans who want to work but need assistance, the Health Security Act promises help. The plan not only offers personal assistance services at home, but also personal care assistance tax credits to make working a more viable option for people with disabilities. Finally, the plan increases financial protections for those on Medicaid who receive care in nursing homes.

Chapter 9

RESPONSIBILITY

"My husband and I are 59 and 63 years of age, so we are not yet eligible for Medicare to help us...A brief summary of our health insurance costs over the last 4 years are:

1988- $3,578 with $500 deductible
1990- $4,607 with $2,500 deductible
1992- $10,500 with $2,000 deductible

"I have a pre-existing condition so I have to pay a penalty on the rates. Neither my husband nor myself, fortunately, has ever had a claim of any kind...

"We do not want a 'free ride.' We are more than willing to pay our share, but these amounts are just too excessive."

M.M.
Joliet, Ill.

Responsibility is central to every one of the principles of the Health Security Act. As the President said in his address to the Joint Session of Congress, "We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution."

All those involved in providing health care will, for the first time, share collective responsibility for the quality of care patients receive, and for keeping patients healthy, not just treating them once they're sick. Health plans will have the responsibility of keeping the costs of

premiums reasonable – there will be no more blank checks for health care. This newfound imperative for responsible health care will mean a change in the way some currently do business.

For insurance companies, responsibility means no longer denying people coverage if they get sick. For unscrupulous medical companies and laboratories, responsibility means an end to fraudulent

MEDICAL MALPRACTICE

Responsibility means bringing common sense to our medical malpractice system. Although experts believe that the direct cost of malpractice accounts for less than two percent of our spending on health care, reform of our existing system is badly needed. We must work to remove the threat of lawsuits that leads to so much "defensive medicine" and drives up costs for everyone. We must free doctors to do what they do best — care for patients — while protecting consumers at the same time. And we must take steps to let lawyers who profit from huge settlements know that they can no longer take advantage of the system.

In an effort to end frivolous lawsuits and protect doctors, the Health Security Act will change tort laws and develop new alternatives to resolve patients' claims against providers before they get to court. The Act will require those who believe they have been the victims of malpractice to first submit their claims to an out-of-court panel to resolve the dispute. If the patient is still unsatisfied with the resolution, the case can be taken to court, but only after obtaining a "certificate of merit," an affidavit from another doctor stating that the patient has good cause to pursue a claim.

billing practices. For lawyers, responsibility means no more filing of frivolous lawsuits. "In short," as the President said, "responsibility should apply to anybody who abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have."

For employers — both large and small — responsibility means

The Act will also:

- Limit attorneys' fees to one-third of an award, and allow states to impose even lower limits;
- Allow damages to be paid over a period of time rather than all at once;
- Prevent injured patients from gaming the system and getting paid twice for the same injury — once by a doctor and a second time by a health or disability insurance plan; and
- Promote progressive ideas such as a program in Maine that frees doctors from malpractice liability if they can demonstrate that they followed prescribed clinical practice guidelines.

Taken together, these steps represent the first serious national effort to take what has been learned in the states and apply it on a national level. Once implemented, these steps will help turn the incentives in our health care system right side up. By restoring responsibility to our medical malpractice system, we can also restore trust to the doctor-patient relationship which lies at the heart of health care.

following the lead of our nation's most successful businesses and helping contribute to the health security of every employee. For every American, responsibility means taking care of your health, rejecting behaviors that drive up health costs, and making a contribution to health coverage. "Responsibility," as the President said, "isn't just about them. It's about you, it's about me, it's about each of us."

Paying for Health Security

Even though our nation spends nearly one of every seven dollars on health care, tens of millions of American lack health security. More than 37 million Americans have no health insurance. More than 25 million Americans have inadequate insurance — so-called "bare bones" coverage or policies that don't cover them when they need it most. And nearly every American family — even those with health insurance — live with the fear and the hard fact that only one pink slip, one seriously ill relative, one misfortune could cost them a lifetime of savings and even their independence and dignity.

Providing all Americans health security will make our nation stronger and bring down health care costs. In the short term, it will take new funds to cover the uninsured and provide those who are now covered with rock solid security and comprehensive benefits. The question is how we will pay and who will pay.

The vast majority of funding for the Health Security Act will continue to come from where it comes from today: employer and employee contributions to the cost of health insurance. New funding will be drawn from three primary sources:

- Asking all employers and the 30 million Americans who work for them but do not have health coverage to contribute to their health care;
- Increasing excise taxes on tobacco and requiring small contributions from large corporations who choose to form their own health alliance;
- Limiting the growth in federal health care programs.

These are the fairest and most workable sources to yield sufficient money and guarantee health security to every American.

Expanding the Current Employer-Based System

The principal way we pay to ensure health security for all Americans is by building on our current system and asking all employers and employees to take responsibility for paying for health coverage.

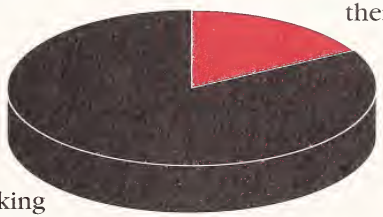
Today, nine out of ten Americans who get health coverage get it through their employer. It's a system that works for the vast majority of Americans. That's why the President rejected any kind of broad-based tax to pay for a government-run system — deciding instead to leave our health care system rooted in the private sector.

Today, most employers and employees contribute to the cost of health coverage, but not all do. Thirty million Americans in working families go without health coverage because they are not covered by their employers.

But these workers still get health care when they need it — often the most expensive kind of health care in the most expensive place: the emergency room. And the rest of us end up paying the bills — in higher premiums, higher taxes and inflated hospital charges.

This phenomenon — what academics call "cost shifting" — contributes to the high health care costs we all are forced to pay. This "cost-shifting" happens on every street in America where you'll find a supermarket, a dry cleaner, or a gas station that doesn't insure its workers. On the next block you'll find a supermarket, dry cleaner, or a gas station that does insure its employees. The businesses that insure pay higher premium costs because they are forced to pick up

85% of uninsured Americans are in working families



Source: 1990 data, Employee Benefits Research Institute, 1992

the tab for their competitors who are not paying.

The Health Security Act asks those who aren't paying to pay their fair share, lowering costs for the vast majority of companies and individuals, who will no longer see their premiums rise to pay for those without insurance. We'll save $25 billion by providing coverage to everyone, because the government will no longer have to reimburse

HAWAII

A Model for Reform

Only one state in America has asked all employers to contribute to the cost of their employees' health care: Hawaii. And it has been able to achieve near-universal coverage while maintaining a thriving economy.

In many ways, the Health Security Act echoes Hawaii's experience. Hawaii passed a health reform plan in 1974 that required all employers to contribute to their workers health care. As part of the reform, Hawaii included special programs to ease the burden for small businesses. The result? A greater percentage of Hawaiians have health insurance, far more than in any other state in the country. Health care costs are significantly lower in Hawaii than elsewhere in the U.S. And only 2% of small firms have sought out a special program for small businesses struggling to provide insurance.

In fact, since Hawaii passed health reform, the unemployment rate there has dropped to one of the lowest in the nation (2.8% in 1991). Meanwhile, small business creation rates have remained high (the number of employers grew almost 200% from 1970 to 1991).

doctors and hospitals for the cost of caring for the uninsured.

While building on our current system ensures that 30 million working Americans will receive health coverage, requiring responsibility from all employers and employees does not alone provide true health security. Additional funding is needed to protect small businesses, provide long-term care and prescription drug coverage to older Americans, and ensure that no American — including those who lose their jobs — ever lose their health coverage.

To guarantee comprehensive benefits for all Americans, the Health Security Act requires the second and third primary sources of funding: a cigarette tax and corporate assessment, and savings from slowing the growth of federal health care programs.

The Cigarette Tax and Corporate Assessment

Cigarette taxes will increase by 75 cents a pack, raising revenue for health reform, and ensuring that those who smoke pay for the health costs that smoking causes. Higher tobacco prices may also have a significant impact in preventing teenagers from ever starting to smoke.

In addition, large corporations that form their own alliances will contribute to help support the backbone of our health care system — academic health centers, advanced medical research, as well as other elements of our health care infrastructure. Asking large corporations to pay one percent of their payroll will support those institutions that benefit every American.

Slowing the Growth of Federal Health Care Programs

The Health Security Act will also produce savings by slowing the skyrocketing growth of government spending on health care programs. Over time, the Health Security Act will slow the rate of growth in Medicare (the government program for seniors and the disabled) and Medicaid (the program that provides health care to the poor) from three times the rate of inflation to roughly two times the rate of inflation.

Upper-income people who receive Medicare — those individuals who earn more than $100,000 per year — will be asked to pay a higher percentage of the cost of coverage than they do today.

People covered by Medicare will see an increase in their benefits under the Health Security Act. Elderly and disabled Americans will receive the prescription drug coverage they need, and a new long-term care program will provide options for home and community-based care.

Most Americans who now receive health care through Medicaid will be part of the same system as other Americans, paying what they can for their care but benefitting from discounts that make coverage affordable.

By controlling costs in both the public and private sector, these savings avoid hurting privately insured people. Today, doctors and hospitals often charge more to private patients to make up for shortfalls in what they are paid to provide care to people covered by Medicare and Medicaid. The Health Security Act slows the growth in federal health care programs as part of fundamental reform that controls the cost of all health care.

These are the three primary sources of private and government funding that will help pay for health security for every American — full responsibility from businesses and individuals, cigarette taxes and a small corporate assessment, and a slowdown in the growth of Medicare and Medicaid. This is a conservative approach that doesn't count on the billions in cost savings that can be achieved from the plan's new emphasis on preventive care, encouraging real competition among health providers, and cracking down on health care fraud. It is an approach that asks responsibility of everyone. In return, it guarantees every American comprehensive health benefits that can never be taken away.

Conclusion

For nearly a century, Americans have discussed and debated how best to reform our national health care system. Since the early 1900s, commissions, committees, groups and organizations have put forth proposal after proposal to overhaul the way our nation delivers and pays for medical care.

In 1915, a group calling for health reform concluded that employers, employees and the government should contribute to the cost of health care, and recommended that the system focus on prevention.

In 1932, a commission decided that we should encourage doctors to form group practices and share responsibility for high quality, cost-effective care.

In 1933, when President Franklin Roosevelt launched the initiative that became the Social Security Act, he intended to include national health insurance.

In 1946, President Harry Truman proclaimed that health care should be a right, not a privilege, and became the first president to introduce a plan for national health reform.

And in 1972, President Richard Nixon told the American people that the only way to insure health coverage for every American was to ask employers to take responsibility and contribute to their workers' care.

Now, in 1993, with one in four of us poised to lose health insurance in the next two years and costs expected to double by the year 2000, our nation stands ready for reform. Since President Clinton took office, more than 260 members of Congress have signed their names to some piece of legislation proposing national health care reform. Democrats and Republicans are teaming up to make history; for the first time, members of both parties have agreed that every American must be guaranteed health care.

The Health Security Act builds on what's best about the American health care system. It maintains and strengthens America's private health care. It extends the current system of employer-based coverage that works well for so many. It protects our cherished right to choose how we receive health care. It invests in improving the quality of our care. It establishes a national framework for reform, but leaves to every state, every community, every doctor, nurse and consumer the right to decide how to give and get health care.

The Health Security Act also reaches out to fix what has gone wrong with our health care system.

First and foremost, it guarantees health security for every American — a comprehensive package of benefits that can never be taken away. For those who have been victims of today's health insurance lottery — those denied insurance because of a pre-existing condition or those who have lost a job and seen their coverage disappear — nothing could be more important. And for those Americans who enjoy good health coverage today, but go to bed at night worried what might happen tomorrow, there could be no more reassuring guarantee.

The Health Security Act takes aggressive steps to bring our runaway health care system under control. It reduces the paperwork that chokes our system, the bureaucracy that forces doctors and nurses to spend hour after hour filling out forms instead of caring for patients. It promotes true competition in the health care marketplace — and reins in skyrocketing costs, making sure insurance premiums no longer rise uncontrollably. And it turns upside down incentives right side up.

The Health Security Act restores responsibility. It requires every employer and individual to pay for health coverage, even if that contribution is small. It recognizes that we can no longer afford to allow some to squeeze excess profits from health care consumers. And it promises swift and stiff penalties to those who take advantage of the system.

The Health Security Act holds the promise of strengthening our economy. It raises no new broad-based taxes, but spends our health care dollars more wisely. It levels the playing field for small business-

es, making it possible for them to insure their families and their employees. It eases the tremendous burden of rising health costs on big business, helping them compete for global markets. And it sets us in the right direction of reducing our national debt.

Finally, the Health Security Act restores common sense to American health care. It protects older Americans and gives them the health benefits they deserve when they need them most. It is based on an approach that it is better to keep people healthy rather than treating them only after they get sick. It borrows from what works today, letting us phase in change at a reasonable pace and adjust our course if needed. It builds on what works best — and makes it work for everyone.

Our nation's health care system has reached a point where change is our only option. As President Clinton said in his address to the Joint Session of Congress:

"Now it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation's health care system won't be there for them when they need it.

"It's hard to believe that there was once a time in this century when that kind of fear gripped old age. When retirement was nearly synonymous with poverty, and older Americans died in the street. That's unthinkable today, because over half a century ago Americans had the courage to change — to create a Social Security system that ensures that no American will be forgotten in their later years.

"Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hardworking families lost their homes, their savings, their businesses — lost everything simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today."

ADDRESS OF THE PRESIDENT TO THE JOINT SESSION OF CONGRESS

September 22, 1993

My fellow Americans, tonight we come together to write a new chapter in the American story. Our forebears enshrined the American Dream — life, liberty, the pursuit of happiness. Every generation of Americans has worked to strengthen that legacy, to make our country a place of freedom and opportunity, a place where people who work hard can rise to their full potential, a place where their children can have a better future.

From the settling of the frontier to the landing on the moon, ours has been a continuous story of challenges defined, obstacles overcome, new horizons secured. That is what makes America what it is and Americans what we are. Now we are in a time of profound change and opportunity. The end of the Cold War, the Information Age, the global economy have brought us both opportunity and hope and strife and uncertainty. Our purpose in this dynamic age must be to change — to make change our friend and not our enemy.

To achieve that goal, we must face all our challenges with confidence, with faith, and with discipline — whether we're reducing the deficit, creating tomorrow's jobs and training our people to fill them, converting from a high-tech defense to a high-tech domestic economy, expanding trade, reinventing government, making our streets safer, or rewarding work over idleness. All these challenges require us to change.

If Americans are to have the courage to change in a difficult time, we must first be secure in our most basic needs. Tonight I want to talk to you about the most critical thing we can do to build that security. This health care system of ours is badly broken and it is time to fix it.

Despite the dedication of literally millions of talented health care professionals, our health care is too uncertain and too expensive, too bureaucratic and too wasteful. It has too much fraud and too much greed.

At long last, after decades of false starts, we must make this our most urgent priority, giving every American health security; health care that can never be taken away, health care that is always there. That is what we must do tonight.

On this journey, as on all others of true consequence, there will be rough spots in the road and honest disagreements about how we should proceed. After all, this is a complicated issue. But every successful journey is guided by fixed stars. And if we can agree on some basic values and principles we will reach this destination, and we will reach it together.

So tonight I want to talk to you about the principles that I believe must embody our efforts to reform America's health care system — security, simplicity, savings, choice, quality, and responsibility.

When I launched our nation on this journey to reform the health care system I knew we needed a talented navigator, someone with a rigorous mind, a steady compass, a caring heart. Luckily for me and for our nation, I didn't have to look very far.

Over the last eight months, Hillary and those working with her have talked to literally thousands of Americans to understand the strengths and the frailties of this system of ours. They met with over 1,100 health care organizations. They talked with doctors and nurses, pharmacists and drug company representatives, hospital administrators, insurance company executives and small and large businesses. They spoke with self-employed people. They talked with people who had insurance and people who didn't. They talked with union members and older Americans and advocates for our children. The First Lady also consulted, as all of you know, extensively with governmental leaders in both parties in the states of our nation, and especially here on Capitol Hill.

Hillary and the Task Force received and read over 700,000 letters from ordinary citizens. What they wrote and the bravery with which they told their stories is really what calls us all here tonight.

Every one of us knows someone who's worked hard and played by the rules and still been hurt by this system that just doesn't work for too many people. But I'd like to tell you about just one.

Kerry Kennedy owns a small furniture store that employs seven people in Titusville, Florida. Like most small business owners, he's poured his heart and soul, his sweat and blood into that business for years. But over the last several years, again like most small business owners, he's seen his health care premiums skyrocket, even in years when no claims were made. And last year, he painfully discovered he could no longer afford to provide coverage for all his workers because his insurance company told him that two of his workers had become high risks because of their advanced age. The problem was that those two people were his mother and father, the people who founded the business and still worked in the store.

This story speaks for millions of others. And from them we have learned a powerful truth. We have to preserve and strengthen what is right with the health care system, but we have got to fix what is wrong with it.

Now, we all know what's right. We're blessed with the best health care professionals on Earth, the finest health care institutions, the best medical research, the most sophisticated technology. My mother is a nurse. I grew up around hospitals. Doctors and nurses were the first professional people I ever knew or learned to look up to. They are what is right with this health care system. But we also know that we can no longer afford to continue to ignore what is wrong.

Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings. Millions more are locked into the jobs they have now just because they or someone in their family has once been sick and they have what is called a preexisting condition. And on any given day, over 37 million Americans — most of them working people and their little children — have no health insurance at all.

And in spite of all this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on Earth. And the gap is growing, causing many of our companies in global competition

severe disadvantage. There is no excuse for this kind of system. We know other people have done better. We know people in our own country are doing better. We have no excuse. My fellow Americans, we must fix this system and it has to begin with congressional action.

I believe as strongly as I can say that we can reform the costliest and most wasteful system on the face of the Earth without enacting new broad-based taxes. I believe it because of the conversations I have had with thousands of health care professionals around the country; with people who are outside this city, but are inside experts on the way this system works and wastes money.

The proposal that I describe tonight borrows many of the principles and ideas that have been embraced in plans introduced by both Republicans and Democrats in this Congress. For the first time in this century, leaders of both political parties have joined together around the principle of providing universal, comprehensive health care. It is a magic moment and we must seize it.

I want to say to all of you I have been deeply moved by the spirit of this debate, by the openness of all people to new ideas and argument and information. The American people would be proud to know that earlier this week when a health care university was held for members of Congress just to try to give everybody the same amount of information, over 320 Republicans and Democrats signed up and showed up for two days just to learn the basic facts of the complicated problem before us.

Both sides are willing to say we have listened to the people. We know the cost of going forward with this system is far greater than the cost of change. Both sides, I think, understand the literal ethical imperative of doing something about the system we have now. Rising above these difficulties and our past differences to solve this problem will go a long way toward defining who we are and who we intend to be as a people in this difficult and challenging era. I believe we all understand that.

And so tonight, let me ask all of you — every member of the House, every member of the Senate, each Republican and each Democrat — let us keep this spirit and let us keep this commitment until this job is done. We owe it to the American people.

Now, if I might, I would like to review the six principles I mentioned earlier and describe how we think we can best fulfill those principles.

First and most important, security. This principle speaks to the human misery, to the costs, to the anxiety we hear about every day — all of us — when people talk about their problems with the present system. Security means that those who do not now have health care coverage will have it; and for those who have it, it will never be taken away. We must achieve that security as soon as possible.

Under our plan, every American would receive a health care security card that will guarantee a comprehensive package of benefits over the course of an entire lifetime, roughly comparable to the benefit package offered by most Fortune 500 companies. This health care security card will offer this package of benefits in a way that can never be taken away.

So let us agree on this: whatever else we disagree on, before this Congress finishes its work next year, you will pass and I will sign legislation to guarantee this security to every citizen of this country.

With this card, if you lose your job or you switch jobs, you're covered. If you leave your job to start a small business, you're covered. If you're an early retiree, you're covered. If someone in your family has, unfortunately, had an illness that qualifies as a preexisting condition, you're still covered. If you get sick or a member of your family gets sick, even if it's a life threatening illness, you're covered. And if an insurance company tries to drop you for any reason, you will still be covered, because that will be illegal.

This card will give comprehensive coverage. It will cover people for hospital care, doctor visits, emergency and lab services, diagnostic services like Pap smears and mammograms and cholesterol tests, substance abuse and mental health treatment.

And equally important, for both health care and economic reasons, this program for the first time would provide a broad range of preventive services including regular checkups and well-baby visits.

Now, it's just common sense. We know — any family doctor will tell you that people will stay healthier and long-term costs of the health system will be lower if we have comprehensive preventive ser-

vices. You know how all of our mothers told us that an ounce of prevention was worth a pound of cure? Our mothers were right. And it's a lesson, like so many lessons from our mothers, that we have waited too long to live by. It is time to start doing it.

Health care security must also apply to older Americans. This is something I imagine all of us in this room feel very deeply about. The first thing I want to say about that is that we must maintain the Medicare program. It works to provide that kind of security. But this time and for the first time, I believe Medicare should provide coverage for the cost of prescription drugs.

Yes, it will cost some more in the beginning. But, again, any physician who deals with the elderly will tell you that there are thousands of elderly people in every state who are not poor enough to be on Medicaid, but just above that line and on Medicare, who desperately need medicine, who make decisions every week between medicine and food. Any doctor who deals with the elderly will tell you that there are many elderly people who don't get medicine, who get sicker and sicker and eventually go to the doctor and wind up spending more money and draining more money from the health care system than they would if they had regular treatment in the way that only adequate medicine can provide.

I also believe that over time, we should phase in long-term care for the disabled and the elderly on a comprehensive basis.

As we proceed with this health care reform, we cannot forget that the most rapidly growing percentage of Americans are those over 80. We cannot break faith with them. We have to do better by them.

The second principle is simplicity. Our health care system must be simpler for the patients and simpler for those who actually deliver health care — our doctors, our nurses, our other medical professionals. Today we have more than 1,500 insurers, with hundreds and hundreds of different forms. No other nation has a system like this. These forms are time consuming for health care providers, they're expensive for health care consumers, they're exasperating for anyone who's ever tried to sit down around a table and wade through them and figure them out.

The medical care industry is literally drowning in paperwork. In

recent years, the number of administrators in our hospitals has grown by four times the rate that the number of doctors has grown. A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy.

Just a few days ago, the Vice President and I had the honor of visiting the Children's Hospital here in Washington where they do wonderful, often miraculous things for very sick children. A nurse named Debbie Freiberg told us that she was in the cancer and bone marrow unit. The other day a little boy asked her just to stay at his side during his chemotherapy. And she had to walk away from that child because she had been instructed to go to yet another class to learn how to fill out another form for something that didn't have a lick to do with the health care of the children she was helping. That is wrong, and we can stop it, and we ought to do it.

We met a very compelling doctor named Lillian Beard, a pediatrician, who said that she didn't get into her profession to spend hours and hours — some doctors up to 25 hours a week just filling out forms. She told us she became a doctor to keep children well and to help save those who got sick. We can relieve people like her of this burden. We learned — the Vice President and I did — that in the Washington Children's Hospital alone, the administrators told us they spend $2 million a year in one hospital filling out forms that have nothing whatever to do with keeping up with the treatment of the patients.

And the doctors there applauded when I was told and I related to them that they spend so much time filling out paperwork, that if they only had to fill out those paperwork requirements necessary to monitor the health of the children, each doctor on that one hospital staff — 200 of them — could see another 500 children a year. That is 100,000 children a year. I think we can save money in this system if we simplify it. And we can make the doctors and the nurses and the people that are giving their lives to help us all be healthier a whole lot happier, too, on their jobs.

Under our proposal there would be one standard insurance form — not hundreds of them. We will simplify also — and we must — the government's rules and regulations, because they are a big part of this

problem. This is one of those cases where the physician should heal thyself. We have to reinvent the way we relate to the health care system, along with reinventing government. A doctor should not have to check with a bureaucrat in an office thousands of miles away before ordering a simple blood test. That's not right, and we can change it. And doctors, nurses and consumers shouldn't have to worry about the fine print. If we have this one simple form, there won't be any fine print. People will know what it means.

The third principle is savings. Reform must produce savings in this health care system. It has to. We're spending over 14 percent of our income on health care — Canada's at 10; nobody else is over nine. We're competing with all these people for the future. And the other major countries, they cover everybody and they cover them with services as generous as the best company policies here in this country.

Rampant medical inflation is eating away at our wages, our savings, our investment capital, our ability to create new jobs in the private sector and this public Treasury. You know the budget we just adopted had steep cuts in defense, a five-year freeze on the discretionary spending, so critical to reeducating America and investing in jobs and helping us to convert from a defense to a domestic economy. But we passed a budget which has Medicaid increases of between 16 and 11 percent a year over the next five years, and Medicare increases of between 11 and 9 percent in an environment where we assume inflation will be at 4 percent or less.

We cannot continue to do this. Our competitiveness, our whole economy, the integrity of the way the government works and, ultimately, our living standards depend upon our ability to achieve savings without harming the quality of health care.

Unless we do this, our workers will lose almost $600 in income each year by the end of the decade. Small businesses will continue to face skyrocketing premiums. And a full third of small businesses now covering their employees say they will be forced to drop their insurance. Large corporations will bear vivid disadvantages in global competition. And health care costs will devour more and more and more of our budget.

Pretty soon all of you or the people who succeed you will be show-

ing up here, and writing out checks for health care and interest on the debt and worrying about whether we've got enough defense, and that will be it, unless we have the courage to achieve the savings that are plainly there before us. Every state and local government will continue to cut back on everything from education to law enforcement to pay more and more for the same health care.

These rising costs are a special nightmare for our small businesses — the engine of our entrepreneurship and our job creation in America today. Health care premiums for small businesses are 35 percent higher than those of large corporations today. And they will keep rising at double-digit rates unless we act.

So how will we achieve these savings? Rather than looking at price control, or looking away as the price spiral continues; rather than using the heavy hand of government to try to control what's happening, or continuing to ignore what's happening, we believe there is a third way to achieve these savings.

First, to give groups of consumers and small businesses the same market bargaining power that large corporations and large groups of public employees now have. We want to let market forces enable plans to compete. We want to force these plans to compete on the basis of price and quality, not simply to allow them to continue making money by turning people away who are sick or old or performing mountains of unnecessary procedures. But we also believe we should back this system up with limits on how much plans can raise their premiums year in and year out, forcing people, again, to continue to pay more for the same health care, without regard to inflation or the rising population needs.

We want to create what has been missing in this system for too long, and what every successful nation who has dealt with this problem has already had to do: to have a combination of private market forces and a sound public policy that will support that competition, but limit the rate at which prices can exceed the rate of inflation and population growth, if the competition doesn't work, especially in the early going.

The second thing I want to say is that unless everybody is covered — and this is a very important thing — unless everybody is covered,

we will never be able to fully put the breaks on health care inflation. Why is that? Because when people don't have any health insurance, they still get health care, but they get it when it's too late, when it's too expensive, often from the most expensive place of all, the emergency room. Usually by the time they show up, their illnesses are more severe and their mortality rates are much higher in our hospitals than those who have insurance. So they cost us more.

And what else happens? Since they get the care but they don't pay, who does pay? All the rest of us. We pay in higher hospital bills and higher insurance premiums. This cost shifting is a major problem.

The third thing we can do to save money is simply by simplifying the system — what we've already discussed. Freeing the health care providers from these costly and unnecessary paperwork and administrative decisions will save tens of billions of dollars. We spend twice as much as any other major country does on paperwork. We spend at least a dime on the dollar more than any other major country. That is a stunning statistic. It is something that every Republican and every Democrat ought to be able to say, we agree that we're going to squeeze this out. We cannot tolerate this. This has nothing to do with keeping people well or helping them when they're sick. We should invest the money in something else.

We also have to crack down on fraud and abuse in the system. That drains billions of dollars a year. It is a very large figure, according to every health care expert I've ever spoken with.

So I believe we can achieve large savings. And that large savings can be used to cover the unemployed uninsured, and will be used for people who realize those savings in the private sector to increase their ability to invest and grow, to hire new workers or to give their workers pay raises, many of them for the first time in years.

Now, nobody has to take my word for this. You can ask Dr. Koop. He's up here with us tonight, and I thank him for being here. Since he left his distinguished tenure as our Surgeon General, he has spent an enormous amount of time studying our health care system, how it operates, what's right and wrong with it. He says we could spend $200 billion every year, more than 20 percent of the total budget, without sacrificing the high quality of American medicine.

Ask the public employees in California, who have held their own premiums down by adopting the same strategy that I want every American to be able to adopt — bargaining within the limits of a strict budget. Ask Xerox, which saved an estimated $1,000 per worker on their health insurance premium. Ask the staff of the Mayo Clinic, who we all agree provides some of the finest health care in the world. They are holding their cost increases to less than half the national average. Ask the people of Hawaii, the only state that covers virtually all of their citizens and has still been able to keep costs below the national average.

People may disagree over the best way to fix this system. We may all disagree about how quickly we can do what — the thing that we have to do. But we cannot disagree that we can find tens of billions of dollars in savings in what is clearly the most costly and the most bureaucratic system in the entire world. And we have to do something about that, and we have to do it now.

The fourth principle is choice. Americans believe they ought to be able to choose their own health care plan and keep their own doctors. And I think all of us agree. Under any plan we pass, they ought to have that right. But today, under our broken health care system, in spite of the rhetoric of choice, the fact is that that power is slipping away for more and more Americans.

Of course, it is usually the employer, not the employee, who makes the initial choice of what health care plan the employee will be in. And if your employer offers only one plan, as nearly three-quarters of small or medium-sized firms do today, you're stuck with that plan, and the doctors that it covers.

We propose to give every American a choice among high-quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a health maintenance organization. If you don't like your plan, every year you'll have the chance to choose a new one. The choice will be left to the American citizen, the worker — not the boss, and certainly not some government bureaucrat.

We also believe that doctors should have a choice as to what plans they practice in. Otherwise, citizens may have their own choices limited. We want to end the discrimination that is now growing against

doctors, and to permit them to practice in several different plans. Choice is important for doctors, and it is absolutely critical for our consumers. We've got to have it in whatever plan we pass.

The fifth principle is quality. If we reformed everything else in health care, but failed to preserve and enhance the high quality of our medical care, we will have taken a step backward, not forward. Quality is something that we simply can't leave to chance. When you board an airplane, you feel better knowing that the plane had to meet standards designed to protect your safety. And we can't ask any less of our health care system.

Our proposal will create report cards on health plans, so that consumers can choose the highest quality health care providers and reward them with their business. At the same time, our plan will track quality indicators, so that doctors can make better and smarter choices of the kind of care they provide. We have evidence that more efficient delivery of health care doesn't decrease quality. In fact, it may enhance it.

Let me just give you one example of one commonly performed procedure, the coronary bypass operation. Pennsylvania discovered that patients who were charged $21,000 for this surgery received as good or better care as patients who were charged $84,000 for the same procedure in the same state. High prices simply don't always equal good quality.

Our plan will guarantee that high quality information is available in even the most remote areas of this country so that we can have high-quality service, linking rural doctors, for example, with hospitals with high-tech urban medical centers. And our plan will ensure the quality of continuing progress on a whole range of issues by speeding the search on effective prevention and treatment measures for cancer, for AIDS, for Alzheimer's, for heart disease, and for other chronic diseases. We have to safeguard the finest medical research establishment in the entire world. And we will do that with this plan. Indeed, we will even make it better.

The sixth and final principle is responsibility. We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution. Responsibility has to start with those

who profit from the current system. Responsibility means insurance companies should no longer be allowed to cast people aside when they get sick. It should apply to laboratories that submit fraudulent bills, to lawyers who abuse malpractice claims, to doctors who order unnecessary procedures. It means drug companies should no longer charge three times more for prescription drugs made in America here in the United States than they charge for the same drugs overseas.

In short, responsibility should apply to anybody who abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have.

Responsibility also means changing some behaviors in this country that drive up our costs like crazy. And without changing it we'll never have the system we ought to have. We will never.

Let me just mention a few and start with the most important — the outrageous cost of violence in this country stem in large measure from the fact that this is the only country in the world where teenagers can rout the streets at random with semi-automatic weapons and be better armed than the police.

But let's not kid ourselves, it's not that simple. We also have higher rates of AIDS, of smoking and excessive drinking, of teen pregnancy, of low birth-weight babies. And we have the third worst immunization rate of any nation in the western hemisphere. We have to change our ways if we ever really want to be healthy as a people and have an affordable health care system. And no one can deny that.

But let me say this — and I hope every American will listen, because this is not an easy thing to hear — responsibility in our health care system isn't just about them. It's about you, it's about me, it's about each of us.

Too many of us have not taken responsibility for our own health care and for our own relations to the health care system. Many of us who have had fully paid health care plans have used the system whether we needed it or not without thinking what the costs were. Many people who use this system don't pay a penny for their care even though they can afford to. I think those who don't have any health insurance should be responsible for paying a portion of their

new coverage. There can't be any something for nothing, and we have to demonstrate that to people. This is not a free system. Even small contributions, as small as the $10 co-payment when you visit a doctor, illustrates that this is something of value. There is a cost to it. It is not free.

And I want to tell you that I believe that all of us should have insurance. Why should the rest of us pick up the tab when a guy who doesn't think he needs insurance or says he can't afford it gets in an accident, winds up in an emergency room, gets good care, and everybody else pays? Why should the small businesspeople who are struggling to keep afloat and take care of their employees have to pay to maintain this wonderful health care infrastructure for those who refuse to do anything?

If we're going to produce a better health care system for every one of us, every one of us is going to have to do our part. There cannot be any such thing as a free ride. We have to pay for it. We have to pay for it.

Tonight I want to say plainly how I think we should do that. Most of the money we will — will come under my way of thinking, as it does today, from premiums paid by employers and individuals. That's the way it happens today. But under this health care security plan, every employer and every individual will be asked to contribute something to health care.

This concept was first conveyed to the Congress about 20 years ago by President Nixon. And today, a lot of people agree with the concept of shared responsibility between employers and employees, and that the best thing to do is to ask every employer and every employee to share that. The Chamber of Commerce has said that, and they're not in the business of hurting small business. The American Medical Association has said that.

Some call it an employer mandate, but I think it's the fairest way to achieve responsibility in the health care system. And it's the easiest for ordinary Americans to understand, because it builds on what we already have and what already works for so many Americans. It is the reform that is not only easiest to understand, but easiest to implement in a way that is fair to small business, because we can give a discount to help struggling small businesses meet the cost of covering their

employees. We should require the least bureaucracy or disruption, and create the cooperation we need to make the system cost-conscious, even as we expand coverage. And we should do it in a way that does not cripple small businesses and low-wage workers.

Every employer should provide coverage, just as three-quarters do now. Those that pay are picking up the tab for those who don't today. I don't think that's right. To finance the rest of reform, we can achieve new savings, as I have outlined, in both the federal government and the private sector, through better decision-making and increased competition. And we will impose new taxes on tobacco.

I don't think that should be the only source of revenues. I believe we should also ask for a modest contribution from big employers who opt out of the system to make up for what those who are in the system pay for medical research, for health education center, for all the subsidies to small business, for all the things that everyone else is contributing to. But between those two things, we believe we can pay for this package of benefits and universal coverage and a subsidy program that will help small business.

These sources can cover the cost of the proposal that I have described tonight. We subjected the numbers in our proposal to the scrutiny of not only all the major agencies in government — I know a lot of people don't trust them, but it would be interesting for the American people to know that this was the first time that the financial experts on health care in all of the different government agencies have ever been required to sit in the room together and agree on numbers. It had never happened before.

But, obviously, that's not enough. So then we gave these numbers to actuaries from major accounting firms and major Fortune 500 companies who have no stake in this other than to see that our efforts succeed. So I believe our numbers are good and achievable.

Now, what does this mean to an individual American citizen? Some will be asked to pay more. If you're an employer and you aren't insuring your workers at all, you'll have to pay more. But if you're a small business with fewer than 50 employees, you'll get a subsidy. If you're a firm that provides only very limited coverage, you may have to pay more. But some firms will pay the same or less for more coverage.

If you're a young, single person in your 20s and you're already insured, your rates may go up somewhat because you're going to go into a big pool with middle-aged people and older people, and we want to enable people to keep their insurance even when someone in their family gets sick. But I think that's fair because when the young get older, they will benefit from it, first; and secondly, even those who pay a little more today will benefit four, five, six, seven years from now by our bringing health care costs closer to inflation.

Over the long run, we can all win. But some will have to pay more in the short run. Nevertheless, the vast majority of the Americans watching this tonight will pay the same or less for health care coverage that will be the same or better than the coverage they have tonight. That is the central reality.

If you currently get your health insurance through your job, under our plan you still will. And for the first time, everybody will get to choose from among at least three plans to belong to. If you're a small business owner who wants to provide health insurance to you family and your employees, but you can't afford it because the system is stacked against you, this plan will give you a discount that will finally make insurance affordable. If you're already providing insurance, your rates may well drop because we'll help you as a small business person join thousands of others to get the same benefits big corporations get at the same price they get those benefits. If you're self-employed, you'll pay less; and you will get to deduct from your taxes 100 percent of your health care premiums.

If you're a large employer, your health care costs won't go up as fast, so that you will have more money to put into higher wages and new jobs and to put into the work of being competitive in this tough global economy.

Now, these, my fellow Americans, are the principles on which I think we should base our efforts: security, simplicity, savings, choice, quality and responsibility. These are the guiding stars that we should follow on our journey toward health care reform.

Over the coming months, you'll be bombarded with information from all kinds of sources. There will be some who will stoutly disagree with what I have proposed — and with all other plans in the

Congress, for that matter. And some of the arguments will be genuinely sincere and enlightening. Others may simply be scare tactics by those who are motivated by the self-interest they have in the waste the system now generates, because that waste is providing jobs, incomes and money for some people.

I ask you only to think of this when you hear all of these arguments: Ask yourself whether the cost of staying on this same course isn't greater than the cost of change. And ask yourself when you hear the arguments whether the arguments are in your interest or someone else's. This is something we have got to try to do together.

I want also to say to the representatives in Congress, you have a special duty to look beyond these arguments. I ask you instead to look into the eyes of the sick child who needs care; to think of the face of the woman who's been told not only that her condition is malignant, but not covered by her insurance. To look at the bottom lines of the businesses driven to bankruptcy by health care costs. To look at the "for sale" signs in front of the homes of families who have lost everything because of their health care costs.

I ask you to remember the kind of people I met over the last year and a half — the elderly couple in New Hampshire that broke down and cried because of their shame at having an empty refrigerator to pay for their drugs; a woman who lost a $50,000 job that she used to support her six children because her youngest child was so ill that she couldn't keep health insurance, and the only way to get care for the child was to get public assistance; a young couple that had a sick child and could only get insurance from one of the parents' employers that was a nonprofit corporation with 20 employees, and so they had to face the question of whether to let this poor person with a sick child go or raise the premiums of every employee in the firm by $200. And on and on and on.

I know we have differences of opinion, but we are here tonight in a spirit that is animated by the problems of those people, and by the sheer knowledge that if we can look into our heart, we will not be able to say that the greatest nation in the history of the world is powerless to confront this crisis.

Our history and our heritage tell us that we can meet this chal-

lenge. Everything about America's past tells us we will do it. So I say to you, let us write that new chapter in the American story. Let us guarantee every American comprehensive health benefits that can never be taken away.

In spite of all the work we've done together and all the progress we've made, there's still a lot of people who say it would be an outright miracle if we passed health care reform. But my fellow Americans, in a time of change, you have to have miracles.

And miracles do happen. I mean, just a few days ago we saw a simple handshake shatter decades of deadlock in the Middle East. We've seen the walls crumble in Berlin and South Africa. We see the ongoing brave struggle of the people of Russia to seize freedom and democracy.

And now, it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation's health care system won't be there for them when they need it.

It's hard to believe that there was once a time in this century when that kind of fear gripped old age. When retirement was nearly synonymous with poverty, and older Americans died in the street. That's unthinkable today, because over a half a century ago Americans had the courage to change — to create a Social Security system that ensures that no Americans will be forgotten in their later years.

Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hardworking families lost their homes, their savings, their businesses, lost everything simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today.

This is our chance. This is our journey. And when our work is done, we will know that we have answered the call of history and met the challenge of our time.

Thank you very much. And God bless America.

Appendix I

MEDICARE/OLDER AMERICANS

Under the Health Security Act, people who get Medicare will receive all the benefits they do today and see little difference in how, where or from whom they receive their care. In addition, there will be an expansion of Medicare benefits to include the cost of prescription drugs. A new program will also be established to provide home and community-based long-term care. The savings from reduced growth in Medicare spending will be rechanneled into those new benefits.

Americans eligible for Medicare will automatically qualify for prescription drug coverage when they enroll in the Part B benefit, which covers physician visits and other outpatient services. Monthly part B premiums will increase by about $11 to cover the cost of this new benefit. However, Medigap policies, the extra coverage many seniors buy to pick up where Medicare leaves off, should decline by a proportionate amount since those policies will no longer cover as much, if any, of the cost of drugs.

With the new prescription drug coverage there is a $250 annual deductible for each person. Individuals on Medicare also pay 20 percent of the cost of each prescription. The maximum amount a person can pay however, is $1,000 over the course of a year. The prescription drug benefit covers drugs and biological products, including insulin, approved by the Food and Drug Administration.

Today, all people covered by Medicare pay 25% of the actual cost of coverage. Under the Health Security Act, higher-income beneficiaries – those individuals who earn more than $100,000 per year – will be asked to pay 75% of the actual cost of coverage.

As health care reform moves forward, Medicare recipients will have more options – with the opportunity to join fee-for-service or other types of health plans, including health maintenance organizations and

preferred provider networks. As Americans enrolled in health plans turn sixty-five, they can choose between remaining in their health plan or getting coverage through Medicare.

MEDICAID

The Health Security Act will integrate Medicaid beneficiaries into the new system, relieving pressures on state budgets and on those who need care but simply cannot afford it.

Under reform, state and federal governments will continue to pay for people receiving cash assistance. Just as private sector employers will make payments for their health coverage, state and federal governments will pay to cover the costs of providing benefits to cash assistance recipients.

Once the state where a person lives enters the new system, people who get Medicaid will enroll in health plans like other Americans, and be able to choose among plans. They will carry the same Health Security card that other Americans carry, providing guaranteeing the comprehensive package of benefits. Medicaid will also offer the services it has now — such as transportation, translation and interpretation, and child care during clinic visits.

People now on Medicaid who do not receive cash assistance will no longer rely on Medicaid. They will be covered like everyone else. Families with incomes less than 150 percent of poverty – less than $22,200 for a two-parent family – will be eligible for discounts on the cost of insurance.

The Health Security Act will enable those people who now stay on welfare to keep their Medicaid benefits to seek employment.

THE DEPARTMENT OF DEFENSE

Under the Health Security Act, the Department of Defense maintains its commitment to military readiness as its first priority while fulfilling its obligation to provide health care to military personnel, their dependents and retirees.

The Secretary of Defense will develop a plan for implementing

health reform and may establish military health plans centered around military hospitals and clinics in the United States. People who are now eligible for CHAMPUS will have the added choice of selected civilian health plans.

Military health plans will meet the same requirements and standards that all health plans meet. They will provide the comprehensive benefits package, and in addition, any other services they currently provide.

In areas in which a military health plan is established, active-duty personnel will automatically enroll. Family members of active duty personnel and retirees who are under the age of 65 will have the opportunity to choose a military health plan or a civilian plan.

Employers of individuals enrolled in military health plans will pay the employer share of the premium, as they do in civilian health plans.

VETERANS HEALTH CARE

Health care reform will honor the nation's commitment to continue providing comprehensive health care to its veterans. Reform will give veterans more choices about how and where they receive care. It will also preserve veterans' benefits and increase the flexibility of the VA health care system.

Under the Health Security Act, the Department of Veterans Affairs will either organize its health centers and hospitals into health plans or allow them to act as health providers and contract with health plans to deliver services.

Health plans organized within the VA system must meet the standards for all health plans.

All veterans may choose to join a VA health plan if one exists in their area. If the health plan can serve only a limited number of people, veterans with service-connected disabilities have first priority for enrollment, followed by low-income veterans.

The Department of Veterans Affairs will continue to provide services that have become its specialty — for example, treatment of spinal cord injuries and post-traumatic stress syndrome, as well as long-term care for elderly and disabled veterans.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Health Security Act is based on a principle embodied in today's FEHB program: broad consumer choice of plans. Under the Health Security Act, federal employees and retirees will join with other members of the communities where they live and choose from among the health plans offered by the regional health alliance.

Federal employees and retirees, like other Americans, will be guaranteed the security of knowing that if they change jobs, lose their job or move, they will still be covered. The benefits package provided in the Health Security Act is based on today's best plans, including several of the type now offered through FEHBP.

Under reform, government contributions will increase for federal workers to 80 percent of the average premium, up from the maximum of 75 percent today.

For current federal retirees, including those eligible for Medicare, the Office of Personnel Management (OPM) will administer a Medigap option to continue the additional protection they currently receive.

INDIAN HEALTH SERVICE

Under the Health Security Act, the Indian Health Service will operate outside the regional alliance system; tribal governments will exercise their full autonomy to devise health care delivery that works for them.

When health reform is implemented, American Indians and Alaskan Natives will have the option to choose whether they want to receive care through the Indian Health Service or through a health plan in a regional alliance.

The Indian Health Service will expand public health and prevention activities, and for the first time may provide some service to non-Indian residents living near reservations. During a five-year period, the Indian Health Service will renovate and expand its clinics to provide all of the services guaranteed in the comprehensive benefits package.

Appendix II

Scenarios Under Reform

TODAY

Under today's system, insurance companies look at dozens of different factors to determine how much they will charge you for health care coverage. Your medical history, your family's medical history, where you live, how old you are, whether you are married, whether or not you are employed, what kind of job you have, whether you are rich or poor, how soon you are likely to have children — these are some of the circumstances they consider when making judgements about what you will pay.

Today's health care system motivates insurance companies to weed out the sick and cover the healthy. Certain populations can only obtain coverage at high prices or can't get coverage at all. Others pay artificially low prices only to find that their insurer drops them when they need health care the most. If you work for a small business or are self-employed, you may have faced the worst of these problems. Insurers may quote you different prices, and you never know what you might pay from one year to the next.

If you have been sick or injured, you could pay a lot for a "bare bones" benefits package. Or, if you are lucky, you may pay a small amount for a good benefits package. You could pay a lot because you have been labeled "high risk." Or, you could pay nothing if your employer pays 100% of your premium. You might not even know what you pay. And you can not be sure that what you pay today will be what you'll pay tomorrow.

THE HEALTH SECURITY ACT

Under the Health Security Act, your premiums will be predictable and easy to figure out. If you are a full-time employee in a business, you and your employer will only need to know whether you are buying

a policy for a single person, a married couple, a single-parent family, or a two-parent family. Employers will all contribute for their workers, and their combined payments will cover 80% of the average-priced plans in that region. Individual contributions will make up the difference — if you choose an average-priced plan, you will pay 20%. If you choose a plan that provides the same comprehensive benefits at a lower price, you will pay less. If your employer pays the entire cost of the premium, as many do today, you will pay nothing at all. If you choose a higher cost plan, you will pay more.

The following scenarios are used to show how much people will pay under reform. The individuals described are not real people, but their situations are illustrative of the impact of health reform. The national average premiums are used to represent the premiums in each alliance, although these amounts will vary by state and by region. These cases are based on average-priced plans, although consumers will be able to choose less expensive plans or more expensive plans.

Policy Type	National Premium*	Family Share (Per Month)	Family Share (Per Year)
Two-Parent Family with Children	$4,360	$73	$872
Single-Parent Family	$3,893	$65	$779
Couple	$3,865	$64	$773
Single Person	$1,932	$32	$386

** 1994 Preliminary Estimates*

EMPLOYER SHARE

The employer share is a fixed amount. Employers only need to know whether their employee is buying a single, couple, or family policy to know what they will pay.

Policy Type	Employer Share
Two-Parent Family with Children	$2,479
Single Parent	$2,479
Couple	$2,125
Single Person	$1,546

** 1994 Preliminary Estimates*

For couples and families — who often have two workers — employers will pay the same amount per worker. This method will be clear and simple for employers and will prevent them from having to go through the complex process of coordinating policies with a spouse's employer or having to suddenly change contributions when there is a divorce or a spouse is laid off. There will be one employer price for family policies, regardless of whether both spouses work, or how many children they have. This will make things simpler for employers — they won't have to coordinate with other companies where their employees' spouses work, or suddenly change contributions in the event of a spouse being laid-off or a couple divorcing. Alliances will calculate the per worker contribution based on the average number of workers in couples and families. For example, since the average family has 1.4 workers, an individual employer's contribution is less than 80% — in fact only 57% of the family premium. When employer contributions are totaled they will add up to 80% of couples and family premiums in the alliance.

TWO-PARENT FAMILY

Today:

Mary Sampson manages a small law office in San Jose, California. She makes $35,000 a year. Her husband, a minister, earns $30,000 a year. Today, they get their coverage through Mary's employer, who pays half their premium. They pay $2,940 a year, 8% of her salary, for their health care premiums alone, not including co-payments and deductibles.

Reform:

Assuming they choose an average-priced plan, the premium for Mary Sampson and her husband will be around $872 a year, or $73 a month. They could choose a higher cost plan, which would cost them more, or a lower-cost plan, which would cost them less.

	Policy Type	Premium	The Sampsons Pay (Per Year)	The Sampsons Pay (Per Month)
TODAY	Two-Parent Family	$5,880	$2,940	$245
REFORM	Two-Parent Family	$4,360	$872	$73

COUPLE

Today:

Dennis and Barbara Rutherford, who live in Hannibal, Missouri have a combined income of $21,200. Dennis was laid off from his high paying job with a large manufacturing firm in late 1990. At that time, both Rutherfords lost their health care coverage. They have been turned down for other coverage because of pre-existing conditions — Dennis' high blood pressure and Barbara's history of breast cancer. Since then, they have been unable to afford the $9,000 a year ($750 a month) premium offered by the only plan that will accept them.

Reform:

If Dennis and Barbara enrolled in an average priced plan, they would pay 20% of the $3,865 annual premium for a couple — $773 a year, or $64 a month. Under reform, insurers will no longer be allowed to use pre-existing conditions to bar the Rutherfords from coverage.

	Policy Type	Premium	The Rutherfords Pay (Per Year)	The Rutherfords Pay (Per Month)
TODAY*	Married Couple	Uninsured	Uninsured	Uninsured
REFORM	Married Couple	$3,865	$773	$64

** Barbara and Dennis were offered a plan costing $9,000 dollars, but were unable to afford it. Today they pay nothing and are uninsured.*

INDIVIDUAL

Today:

Sara Bender, a 28-year-old broadcast journalist, lives in Columbus, Ohio, and makes $34,000 a year. Because she works for a firm which gets a lower cost premium for its healthy workers, she has been paying only $300 a year, or $25 a month for her health care coverage.

Reform:

If Sara enrolled in an average cost plan she would pay 20% of the $1,932 annual premium for a single policy — $386 a year, or $32 a month. Sara will pay more, but she will have the security of knowing that her coverage will always be there, and that her costs won't rise unexpectedly as she gets older.

	Policy Type	Premium	Sara Pays (Per Year)	Sara Pays (Per Month)
TODAY	Single Person	$1,200	$300	$25
REFORM	Single Person	$1,932	$386	$32

SELF-EMPLOYED CONSULTANT

Today:

Susan Addington is a single parent living in Virginia. She is self-employed with an income of $40,000 a year. Because her son has a serious chronic illness, she paid $3,000 in out-of-pocket costs and $5,000 in insurance premiums in just one year. Because she is self-employed, she was only able to deduct 25% of her $5,000 premium or $1,250 of these costs.

Reform:

For the family share of her premium, for an average-priced plan, Susan will pay 20% of the $3,893 annual premium for a single parent family — $779 a year. She will also pay the employer share for a single parent — $2,479, for a total of $3,258-a-year or $272 a month. And she will be able to deduct 100% of the premium.

	Policy Type	Premium	Family Share	Employer Share	Susan Pays (Per Year)	(Per Month)
TODAY	Single Parent	$5,000	NA	NA	$5,000	$417
REFORM	Single Parent	$3,893	$779	$2,479	$3,258	$272

SMALL BUSINESS

Today:

Mr. and Mrs. Jones, who have two children, own a flower shop which is incorporated. They have three employees — Matt, Jane, and Scott. Matt is a 16-year-old high school student who comes to work part-time after school. Jane and Scott are both single and work at the shop full-time. Their average payroll, which includes the Jones's salary, is $17,000 per year per worker.

Last year, Mr. and Mrs. Jones could not afford to provide health insurance for their employees. However, they did independently purchase a policy to cover their family — at a cost of $5,200.

Reform:

Without any discounts, the flower shop will pay the employer share of $1,546 each for Scott and Jane for a single person policy, and $2,479 each for Mr. and Mrs. Jones for a two-parent policy — a total of $8,050.

As a result of discounts offered to small business, the flower shop's contribution for each employee will be limited to 5.3% of the average payroll however. The flower shop will pay no more than $901-per-year or $75-a-month for each worker. For all four workers and their dependents, the cost will total no more than $3,604 per year.

Because Matt is covered under his parent's policy, the flower shop will not contribute towards his health insurance.

In addition to what they pay as owners of the shop, Mr. and Mrs. Jones will pay the employee share of their family policy — $872 per year if they enroll in an average-priced plan. In total, Mr. and Mrs. Jones will have family coverage for $2,674 per year — saving $2,525 from what they are currently paying.

Another way of looking at it is that for $4,476 — $2,674 for the Jones' family coverage and $901 each for Jane and Scott — they will provide coverage for themselves and their employees.

UNION WORKER

Today:

Aleesha Maiuz is a factory worker in St. Louis, Missouri, making $36,000 a year. As a union member, she receives comprehensive benefits for which her employer pays the full amount. Her husband works at a local grocery store which does not offer health care coverage. He is covered under Aleesha's plan.

Reform:

Under the Health Security Act, Aleesha's employer will still be able to provide 100% of health benefits. Her employer's contribution for a family premium will be sharply reduced because the cost of families will be spread across all employers, and her employer will no longer be indirectly paying the unpaid medical bills of the uninsured. Lower costs for the company may mean an increase in wages for Aleesha, and will mean that Aleesha's benefits are more likely to be preserved in the future.

TEACHER

Today:

Jonathan O'Hara teaches sixth grade in Des Moines, Iowa, making $28,000 a year. Under his union contract, he receives comprehensive benefits at no personal cost. His wife, Rebecca, is a nurse, and is covered under Jonathan's plan.

Reform:

Under the Health Security Act, Jonathan and Rebecca will continue to receive the comprehensive package of benefits they receive today. They will stand a better chance for wage increases over time because the local school district, like other employers that have offered generous benefits, will see its premium costs go down. Under reform, it will no longer be indirectly paying for the unpaid medical bills of the uninsured.

In addition, the school district will see its costs go down because the hospital where Rebecca works will begin contributing to the cost of their family policy. Under reform, businesses that employ two-earner couples will no longer bear the cost of family coverage alone.

PROFESSIONAL COUPLE

Today:

Michael and Elizabeth Sands work and live in Memphis, Tennessee, and together earn almost $90,000 a year. Elizabeth is a graphic artist, making $40,000. Although Elizabeth's firm offers her health insurance, the couple chooses to receive their coverage through the architectural firm where Michael works, because it provides a more generous, comprehensive benefits package. Today, the Sands pay $720 a year, or $60 a month, for this coverage. The total premium costs $4,400 a year, and the architecture firm pays the rest.

Reform:

The Sands want to stay with their current plan. Under reform, this plan will cost less than it does today because it will no longer pay for the uncompensated care delivered to the uninsured, saving 10% of the current premium cost.

The average cost of a couple premium in the Sands' alliance is $3,865 but the Sands pick a plan that will cost $4,000. They will pay the difference between 80% of the average cost plan, which is $3092, and $4,000, or $908 a year, $75 a month.

Under reform, the Sands may pay their family share either by having it subtracted from his paycheck or from hers. For fifteen dollars more a month, the Sands will be getting the same high quality, comprehensive benefit package they do today, but with the assurance that they can never lose it.

	Policy Type	Premium	The Sands Pay (Per Year)	(Per Month)
TODAY	Married Couple	$4,400	$720	$60
REFORM	Married Couple	$4,000	$908	$75

LOW-INCOME FAMILY

Today:

Lars and Brenda Gustafson recently had a new baby, and Brenda resigned from her job shortly before the baby was born. Lars works for a messenger service in Minneapolis, Minnesota and takes home about $250 a week, or $13,000 a year. His employer does not offer him health insurance. As a result, he and his family have been uninsured for over two years and are struggling to pay the hospital bill from the birth of the baby.

Reform:

Provided Lars and Brenda choose an average price plan, they will pay 20% of $4,360 or $872 for a two-parent family policy. However, because Lars is in a two-parent family with income less than $14,781 a year, Lars is eligible for a discount, reducing his premium to $384 a year.

	Policy Type	Premium	The Gustafsons Pay (Per Year)	(Per Month)
TODAY	Two-Parent Family	$0	$0	$0
REFORM	Two-Parent Family	$4,360	$384	$32

LOW-INCOME COUPLE

Today:

Linda Bradley, from Beaver Dam, Wisconsin, works in a local print shop making $13,570 a year. Her husband Doug is a freelance photographer but has been unable to find work in the last year. Today, they pay $50 a month for a meager benefit package they obtain through Linda's employer. Her employer, a small business, contributes $600 a year, half the premium. The policy has a high deductible and provides limited benefits.

Reform:

Because Linda and Doug select an average-priced plan and their combined income is below 150% of poverty, they are eligible for a discounted premium of $503 a year, or $42 a month, for comprehensive coverage.

	Policy Type	Premium	The Bradleys Pay (Per Year)	(Per Month)
TODAY	Married Couple	$1,200	$600	$50
REFORM	Married Couple	$3,865	$503	$42

PART-TIME WORKER WITH NO NON-WAGE INCOME

Part-time workers (defined as working more than 10 but less than 30 hours a week), who have no non-wage income, will pay 20% of the premium in their area for their policy type, assuming they enroll in an average-priced plan. Their employers will pay a pro-rated amount of the employer share based on the number of hours worked.

Today:

Lee Harris, of Cleveland, Ohio, was laid off from her job after a big downsizing at her former company. Lee was unemployed for over a year and recently took a job delivering pizzas 20 hours a week. Lee makes $10 an hour and has no non-wage income. Lee can only afford a bare bones policy which costs her $840 a year. Her employer contributes nothing towards her coverage.

Reform:

Assuming Lee picks an average-priced plan, she will pay 20% of the individual policy — $386 a year, or $32 a month. Her employer will only pay two-thirds of the employer share for a single person — $1,033 a year, or $86 a month. Since Lee has no non-wage income, federally-funded discounts will pay for one third of the employer premium.

	Policy Type	Premium	Lee Pays (Per Year)	Lee Pays (Per Month)
TODAY	Single Person	$840	$840	$70
REFORM	Single Person	$1,932	$386	$32

PART-TIME WORKER WITH NON-WAGE INCOME

Part-time workers with substantial non-wage income, for example those with most of their income from rental property, are liable for the remaining portion of the employer share.

If you work ...	Your employer pays	You pay ...
10 hours	1/3 of employer share	2/3 of employer share
15 hours	1/2 of employer share	1/2 of employer share
20 hours	2/3 of employer share	1/3 of employer share

Today:

Mary Wortheimer is a 45-year-old widow who receives $60,000 a year from her husband's estate. She works 10 hours a week at a local boutique. She makes an extra $6,000 a year at the shop for a total income of $66,000 a year. She buys a single policy for herself at a cost of $1,800 a year.

Reform:

The boutique will pay one third of the employer premium — $516 per year, or $43 per month. If she enrolls in an average-priced plan, Mary will pay 20% of the individual policy premium — $386 a year or $86 a month in her area. Because Mary has substantial non-wage income and works one third of the week, Mary is also responsible for two thirds of $1,549, the employer share for a single policy — $1,033 per year, or $86 per month. Mary's total health insurance premium will be approximately $1,419 per year, or $118 a month.

	Policy Type	Premium	Family Share	Employer Share	Mary Pays (Per Year)	(Per Month)
TODAY	Single Person	$1,800	NA	NA	$1,800	$150
REFORM	Single Person	$1,932	$386	$1,033	$1,419	$118

SELF-EMPLOYED FARMER

Today:

James Huggins, a self-employed family farmer in Kansas, makes $25,000 a year and has struggled to pay for health care coverage for himself, his wife and his 10-year-old son. James, like many rural residents, has had trouble getting and keeping insurance. And unlike a business, he is only able to deduct one fourth of the $4,000 he pays in premiums each year.

Reform:

If James enrolls in an average cost plan, he will pay 20% of the $4,360 annual family premium or $872 a year. Like a business, James will also pay the employer share of his premium, which would normally be $2,479. However, that amount would exceed 7.9% of James' $25,000 income, the limit on what employers are required to pay. Instead James will pay 7.9% of $25,000 or $1,975 for his employer share. James will pay a total of $2,847 a year, or $237 a month. For the first time, James Huggins will be also be able to deduct from taxable income the full cost of his health care premiums.

	Policy Type	Premium	Family share	Employer Share	James Pays (Per Year)	(Per Month)
TODAY	Two-Parent Family	$4,000	NA	NA	$4,000	$333
REFORM	Two-Parent Family	$4,360	$872	$1,975*	$2,847	$237

**Capped at 7.9%*

MEDICARE BENEFICIARY

Medicare beneficiaries will have the same guaranteed health security they have today, plus a new prescription drug benefit that will be integrated into Medicare Part B. Beneficiaries will continue to pay their Part B premium just as they do today. They will pay an additional $11-a-month for the new prescription drug benefit.

Today:

Claude and Gertrude Anderson are retired farmers living on a fixed income of about $40,000 a year in West Virginia. Today, they receive Medicare coverage and pay $36.60 for their Part B premium. They also buy a Medigap policy for $1,200 a year to help cover their prescription drug costs, co-payments and deductibles.

Reform:

Under reform, Claude and Gertrude will be covered by a new prescription drug benefit through the Medicare program. They will pay $11-a-month for this new benefit. It will provide them with coverage for 80% of their monthly $300 prescription drug costs after they meet a $250 deductible. And they will not pay more than $1,000 a year in prescription drug costs.

The Andersons will continue to pay their Medicare Part B premium just as they do today. The $100-a-month the Andersons pay for their Medigap policy will either decline to account for the new Medicare drug coverage, or cover additional services.In addition, Medicare certified managed care plans, which frequently have lower deductibles and co-payments, will be more available as an option.

	Policy Type	Part B Premium (Per Month)	Prescription Drug Premium (Per Month)	The Andersons Pay (Per Month)
TODAY	Medicare Beneficiary	$36.60	$0	$36.60
REFORM	Medicare Beneficiary	$36.60	$11	$47.60

** 1993 Medicare Part B premium; 1994 projections have not been released as of the writing of this book*

WORKING MEDICARE BENEFICIARY

Working Medicare beneficiaries will join the alliances in their areas. While they are working, their employers will pay the employer share of their premium. Just like everyone else, they will pay 20% of the premium for their policy type if they enroll in an average-priced plan.

Today:

Larry Watson is a 68-year-old Medicare beneficiary who works in a law firm in Omaha, Nebraska. Today, he pays $36.60 a month for his Part B premium. His employer pays nothing towards his health care coverage.

Reform:

Under reform, Larry will be able to get his Medicare coverage through his local health alliance and receive the guaranteed comprehensive package of benefits. His employer will pay the employer share of the single person premium, and Larry will pay 20% of the average premium in his alliance assuming to enrolls in an average-priced plan — $386 a year, or $32 a month.

	Policy Type	Premium	Larry Pays (Per Year)	Larry Pays (Per Month)
TODAY	Working Medicare Beneficiary	NA	$439	$36.60
REFORM	Working Medicare Beneficiary	$1,932	$386	$32

** When Larry stops working, Medicare will pay for his benefits. Larry will pay the Part B premium and the $11-a-month for prescription drug coverage.*

MEDICAID BENEFICIARIES (AFDC AND SSI)

The federal and state governments will continue to make payments for health coverage for individuals eligible for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, instead of paying doctors and hospitals directly, Medicaid will pay premiums to the alliance.

Today:

Pamela Johnson is a single, unemployed mother of two young children. Because she has only $300 in savings and is earning no income, she qualifies for cash assistance through the AFDC program, and she and her children receive their health insurance through the Medicaid program in their home state of Vermont. She has encountered numerous doctors who refuse to treat her because of low Medicaid reimbursement rates. In addition, Pamela would like to get off welfare and return to work, but she can't afford to lose her Medicaid coverage for herself and her two children.

Reform:

Just like everyone else, Pamela and her children will be able to enroll in a health plan through the regional alliance. For the first time, Pamela will have a choice about which health plan to enroll in. She will receive the same comprehensive package of benefits as everyone else. Medicaid will cover the cost of the average family premium in the alliance. If Pamela chooses a plan with average or below-average costs, she will be responsible only for her co-payments. If she chooses a more expensive plan, she will pay the portion of her premium that is above the average in her alliance.

Pamela and her children will continue to be eligible for supplemental services, such as non-emergency transportation, currently offered by Medicaid programs. If they join an HMO she will pay a $2-per-visit rather than the standard $10-per-visit. For the first time, Pamela will have the freedom of knowing that she will have health care coverage, making it more feasible to go to work.

MEDICAID BENEFICIARIES WHO DO NOT RECEIVE AFDC OR SSI

Today:

Alexandra Warren is single, and works as a waitress at George's Coffeehouse in rural California at minimum wage. Although her annual income is 115% of poverty, she is eligible for Medicaid because she has a chronic and costly illness which requires frequent hospitalization and which, when the costs are deducted from her income, makes her eligible for Medicaid in her state.

Reform:

Under reform, Alexandra will no longer rely on Medicaid for her health benefits. She will select a health plan through the regional alliance, and share the costs of her coverage with her employer. Since Alexandra earns only $8,256 a year — less than 150% of poverty — she will be eligible for a discounted premium. Alexandra will pay $267 a year, or $22 a month if she chooses an average-cost plan.

	Policy Type	Premium	Alexandra Pays (Per Year)	(Per Month)
TODAY	Single Person	Medicaid Pays		
REFORM	Single Person	$1,932	$267	$22

CHILD WITH DISABILITIES

Today:

Alec Moore is a 10-year-old child with severe cerebral palsy. He lives at home with his parents. Both of Alec's parents work outside the home, but because of his condition they cannot afford health insurance. Today, Alec receives Medicaid coverage because his state provides Medicaid coverage to "medically needy" individuals who, although they do not meet the normal income criteria for Medicaid, have medical expenses that are very hig.

Reform:

Under reform, Alec will continue to receive all of the services he is eligible for today. His parents will obtain health insurance through their employers, and their policies will cover him for all services included in the comprehensive benefits package.

Both their employers and Alec's family will gain from health reform: Alec will have the guarantee of health security with no lifetime limits on coverage. His parents will know that they will never confront a situation in which they will be unable to obtain coverage because of his condition. Their employees will not be faced with the dilemma of unusually high premiums caused by having someone with high medical costs in their health insurance group.

Assuming they choose an average cost plan, Alec's parents will pay 20% of the premium for a family plan, $872 a year, or $73 a month.

UNDERGRADUATE STUDENT

Today:

Jason Loewith is a 19-year-old sophomore at Tulane University in New Orleans. His parents, who claim Jason as a dependent for tax purposes, live in Connecticut. He pays nothing for his health insurance because he is covered under his family's plan. Jason works for the University part-time, in the admissions office.

Reform:

Because he is a dependent student, Jason's family will continue to pay for his coverage through their alliance in Connecticut. That alliance will transfer a portion of the family's premium to an alliance in Louisiana, which will provide Jason's coverage. Neither Jason nor his employer, the university, will contribute to his premium costs, because of his status as a student and a dependent.

UNEMPLOYED INDIVIDUAL

Today:

Last year, Ann Tilson, a travel agent in a small company in Vidalia, Georgia, was diagnosed with multiple sclerosis. As a result, her employer's insurance company raised their premiums substantially. Ann later had to quit her job.

Today, Ann cannot get coverage from any other insurer for her pre-existing condition, so she elected, under the COBRA law, to remain insured by the same company that provided her coverage when she worked for the travel agency. Although she has insurance, she is responsible for paying the entire $625 monthly premium herself. Ann's parents help her with the money.

Reform:

Because Ann is unemployed and has no non-wage income other than unemployment insurance, Ann will not have to pay for her health coverage until she finds a new job. Ann will receive the guaranteed benefits package and will continue to be able to see the same doctor she sees today.

When Ann finds work, her employer will be responsible for the employer contribution and she will be responsible for the employee contribution but, unlike today, those contributions will be both predictable and affordable, and she will not pay extra for her health coverage because she has multiple sclerosis.

FEDERAL EMPLOYEE

Today:

Corinne Quigley is a 38 year old employee of the U.S. Department of Agriculture. She and her husband and two children live in Washington DC. Corrine obtains her health insurance through the Federal Employees Health Benefits Plan (FEHBP), which combines all federal employees in the area into a large purchasing pool to offer a large number of insurance plans. All federal employees, including Corinne, have a broad range of plans to choose from, and the same premium applies to all federal employees of a given family size, regardless of age or health status. Corinne pays $1,000 a year or $83 a month.

Reform:

Under reform, federal employees like Corinne will join the regional alliance with other residents in their area. Similar to the FEHBP, an alliance will offer an array of health plans, and the same premium will be charged, regardless of age or health status. All members will have many plans to choose from, and will be able to change plans once a year. Assuming the Quigleys enroll in an average-priced plan, they will pay 20% of the average family premium in their alliance — $872 a year, or $73 a month.

	Policy Type	Premium	The Quigleys Pays (Per Year)	(Per Month)
TODAY	Two-Parent Family	$4,000	$1,000	$83
REFORM	Two-Parent Family	$4,360	$872	$73

VETERANS

Veterans with service-connected disabilities and low-income veterans will be eligible to receive the nationally guaranteed comprehensive benefit package through the Department of Veteran Affairs with no co-payments or deductibles. They will continue to be eligible for supplemental services offered by VA, such as treatment for post-traumatic stress disorder, and certain dental services.

Today:

Al Green, a 52-year-old single veteran, lives in Ann Arbor, Michigan and works in a neighborhood store. Al lost a leg in the Vietnam War, and he receives his health care free-of-charge from the VA.

Reform:

Al will have the opportunity to choose from among several health plans offered through his alliance. If Al opts to receive his health care through another health plan and chooses an average-cost plan, he will pay 20% of the individual policy — $386 a year, or $32 a month. The store where he works will pay the employer share.

If he chooses the VA plan, Al's employer will pay the employer share of his premium, and the VA will pay his 20% share of the premium to the alliance.

"Every American must have the security of comprehensive health benefits that can never be taken away."

President Bill Clinton